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# Interrelationships of caregiving characteristics, burden of caregiving, depressive symptomology, physical health, self-care, life satisfaction and social support of social workers

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INTERRELATIONSHIPS OF CAREGIVING CHARACTERISTICS, BURDEN OF  
CAREGIVING, DEPRESSIVE SYMPTOMOLOGY, PHYSICAL HEALTH, SELF-CARE,  
LIFE SATISFACTION AND SOCIAL SUPPORT OF SOCIAL WORKERS

A Thesis

Submitted to the Graduate Faculty of the  
Louisiana State University and  
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The School of Social Work

by

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## **ABSTRACT**

With increasing numbers of Americans engaged in unpaid, informal caregiving for adults over the age of 18, there is a need for research that investigates caregivers' experiences, with particular emphasis on their health and well being. This is the first known study to examine the experiences of social workers, engaged in direct practice, who are also managing responsibilities related to informal caregiving. The study examined interrelationships among social workers' caregiving characteristics, burden of caregiving, depressive symptomology, physical health, self-care, life satisfaction and social support. Hypotheses included: (1) Burden of caregiving is positively correlated with depressive symptomology. (2) The burden of caregiving is negatively correlated with physical health, self-care and life satisfaction. (3) Amongst social workers with additive caregiving characteristics, social support is positively correlated with both self-care and life satisfaction. Gender differences were examined ad hoc. An anonymous Internet-based survey instrument was distributed to 1,869 Licensed Clinical Social Workers working in a southern state. Among 657 respondents, 120 were unpaid caregivers and comprised the final study sample. Study sample participants were primarily middle-aged Caucasian women who had an average of 23.5 years of social work experience. Over half of all respondents provided informal care for a parent, while others reported caregiving for adult children, relatives, spouses, or friends. The majority of participants devoted fewer than 20 hours per week to caregiving in their own home, the care recipient's home, or another setting. Results showed that the burden of caregiving was significantly and negatively associated with participants' self-perceived health. Intercorrelations emerged among social support, self-care, and life-satisfaction. Results also showed significant gender differences in the practice of self-care, specifically female social workers engaged in self-care more regularly than male social workers. The current study may

inform practice by providing social workers and their employers with greater insight regarding issues related to training and supervision, and has the potential to positively impact agency policies that are responsive to high-risk employees, such as those engaged in informal caregiving.

## **CHAPTER 1: INTRODUCTION**

For social workers, the biopsychosocial consequences associated with compassion fatigue are well documented (Figley, 1995; 2002). What is not understood is the extent to which social workers engage in informal caregiving, i.e. providing unpaid care for adults over the age of 18, in addition to their professional responsibilities. What is more, the consequences of assuming these dual roles are not known. National data show 1 in 5 Americans are caregivers to adults, and roughly 75% of caregivers also work full or part time (AARP Public Policy Institute, 2011). Research in business literature shows how personal caregiving can negatively affect productivity and performance, disrupt career paths, reduce management status and salary expectations, and drain financial resources (National Alliance for Caregiving & the National Center on Women and Aging at Brandeis University, 1999). Social workers who assume informal caregiving responsibilities may experience similar negative consequences both at home and in the workplace.

### **Problem Statement**

There is a gap in the literature examining compassion fatigue among social workers who also provide informal caregiving. The current study addresses this gap in the research by examining the interrelationships amongst caregiving characteristics, burden of caregiving, physical health, depressive symptomology, self-care, life satisfaction and social support. It is expected that caregiving will be positively correlated with depressive symptomology. Further, it is expected that among social workers, the burden of caregiving responsibilities will be negatively correlated with physical health, self-care and life satisfaction. Finally, amongst social workers with additive caregiving responsibilities, social support will be positively correlated with self-care and life satisfaction.

## **Scope Of The Problem**

According to the National Alliance for Caregiving (NAFC) and AARP (2009), more than 65 million Americans identify themselves as caregivers for a relative, friend or adult child over the age of 18 years. The economic value of that care was conservatively estimated as \$450 billion dollars per year, up 20% since 2007, and on par with the federal-state cost of Medicaid (\$438 billion) in 2011 (AARP Public Policy Institute, 2011).

Historically and today, women provide the bulk of in-home care. The average unpaid informal caregiver is female (66%), age 49 years (AARP Public Policy Institute, 2011). Almost 40% have children or grandchildren also living at home (NAFC & AARP, 2009). Caregivers identified primary reasons for providing care to parents, relatives or adult children as being due to the general affects of aging, chronic health conditions, Alzheimer's or dementia, mental illness, cancer and stroke (NAFC & AARP, 2009). As rising numbers of women delay having children, and the population simultaneously lives longer, age-related issues will increase substantially with the percentage of people aged 65 or older growing from 13% in 2008 to 20% by 2030 (Pierret, 2006; United States Census Bureau, 2008). The Center for Disease Control and Prevention (2009) expects the numbers of caregivers to rise 25% to 81 million Americans by the same year.

Caregivers devote approximately 20 hours per week, or more than 1,000 hours per year, assisting care recipients with activities of daily living (ADL) as well as managing doctors visits, transportation, insurance and more (AARP Public Policy Institute, 2011). The experience of informal caregivers is as varied as are care recipients. The intensity, number of hours spent daily and duration of caregiving is determinate of the burden experienced by those providing care (NAFC & AARP, 2009). Those caring for friends or family members with Alzheimer's are



estimated to experience the greatest burden, providing as many as 70 hours per week of care (AARP Public Policy Institute, 2011).

Despite near parity in the workplace in the number of men and women employed, women represent 66% of care providers (NAFC & AARP, 2009). The greatest toll of caregiving may be felt by female members of the sandwich generation, who have children under the age of 18 years of age and provide assistance to aging parents (Pierret, 2006). Women also represent 81% of licensed social workers (Center for Health Workforce Studies, & NASW Center for Workforce Studies, 2006). This intersection of women, caregivers and social workers is the heart of this research study. While the specific consequences of informal caregiving on social workers is not known, it is well documented that caregiving may negatively affect caregivers physical and mental health (AARP Public Policy Institute, 2011). According to the AARP Public Policy Institute (2011) between 40 and 70 of unpaid caregivers experience depressive symptomology. As many as 35% of all caregivers rate their own physical health as being compromised by chronic ailments such as heart disease, immune deficiency, elevated blood pressure, stroke, insomnia, or substance use (AARP Public Policy Institute, 2011).

Social workers face similar negative consequences of professionally providing long-term care to clients in distress. Figley (2002) pointed out that social work, while rewarding, may also manifest in chronic stress as helping professionals empathize with clients (2002). In their three-year longitudinal study examining the impact of burnout on the physical health of licensed social workers ( $n=406$ ), Kim, Ji, and Kao (2011) concluded the demands associated with caring for others frequently cause social workers physical and psychological distress. Similarly, Strozier and Evans (1998) found in their national study that social workers ( $n=668$ ) experienced high levels of distress as the result of their work. In an earlier study by Deutsch (1985), among 264

therapists, 44% of which were social workers, responded that they struggled with issues related to depression, substance abuse, relationships and suicide. While caregiving was not specifically identified as a cause of social worker distress, Figley's (1995) definition of compassion fatigue as the cost of helping professionals' chronic caring, echoes Pearlin, Mullan, Semple, and Skaff's (1990) research on caregiving and the stress process.

The consequences of caring have been vetted by the business sector examining the spillover affects of informal caregiving. Notably, the MetLife Mature Market Institute Juggling Act Study (NAFC & the National Center on Women and Aging at Brandeis University, 1999) of informal caregivers ( $n=1,509$ ) is frequently cited for its contribution to better understanding the experiences of caregivers at home and in the workplace. Findings include employees strapped with job responsibilities and caregiving at home balance both roles with difficulty (NAFC & the National Center on Women and Aging at Brandeis University, 1999). Caregiving while employed frequently results in loss of work productivity, full or part days off, use of work time to manage care recipients health care needs, or needing to otherwise adjust work schedules (NAFC & the National Center on Women and Aging at Brandeis University, 1999). What is more, the MetLife Juggling Act Study (NAFC & the National Center on Women and Aging at Brandeis University, 1999) revealed that as many as one-third of the employed caregivers surveyed felt caregiving had negatively affected their career and earnings through losses of promotion opportunities, skills training or inability to take assignments that included travel. Caregiving was also noted as significantly contributing to chronic physical and mental health conditions such as migraine headaches, high blood pressure, depression and anxiety (NAFC & the National Center on Women and Aging at Brandeis University, 1999).

Bringing these trends into sharp focus, Talley and Crews (2007) declared caregiving a national health emergency and asserted the situation demands attention from the health care community regarding the psychological, emotional and physical toll it exacts on caregivers. Based on the scope of this issue, their warning is not hyperbole. Without question a real crisis exists within the health care community and has far-reaching implications for society as a whole.

### **Theoretical Significance**

#### **How can the study help our understanding of the issue?**

The current study seeks to expand the body of literature by investigating the consequences of caregiving by describing the relationship between caregiving, depressive symptomology, physical health, self-care, life satisfaction, and social support, amongst social workers. The negative consequences of caregiving on productivity of the American workforce are well documented in the literature. Giovannetti, Wolff, Frick, and Boulton (2009) show that the burden of caregiving is negatively correlated with work productivity, and positively correlated with depressive symptomology. Their study of caregivers ( $n=308$ ) is consistent with the findings of The MetLife Study of Working Caregivers and Employer Health Care Costs (Albert & Schulz, 2010), which surveyed employees ( $n=17,097$ ) working in the manufacturing sector. The MetLife Study (Albert & Schulz, 2010) found those with caregiving responsibilities, 40% of which were women, were less healthy and suffered from more chronic illnesses such as hypertension, diabetes and depression, than those without caregiving responsibilities. An extensive review of the literature revealed no such study examining the toll of informal caregiving on social workers. Therefore, the current research will contribute to the research on compassion fatigue by determining the interrelationships amongst caregiving characteristics, burden of caregiving, depressive symptomology, physical health, self-care, life satisfaction, and social

support. The results may yield implications for supervision and training for those social workers balancing their clients' needs with personal caregiving responsibilities.

### **What theories exist if any to explain the phenomena?**

Siebert and Siebert (2007) contend that Mcall and Simmons' (1978) role identity theory explains social workers' proclivity for caring personally and professionally. Social workers, like other helping professionals, choose their profession because they identify within themselves personality traits, characteristics, professional ethics and willingness to assist disadvantaged populations. However, according to Siebert and Siebert (2007), role identity as helper, leads them to take on additional caring roles – at work and at home - while frequently abstaining from seeking help for their own distress. While Sieber (1974) and Baruch and Barnett (1986) theorize that men and women often thrive when challenged with numerous roles and responsibilities, Pearlin et al. (1981) counter that taking on too many roles may be a catalyst for damaging stress leading to role strain, and potentially depressive symptomology

Figley (1995) defines secondary traumatic stress, also referred to as compassion fatigue, as the direct consequence of listening to and actively engaging with a person who has been traumatized. Social workers, by the very nature of their work with vulnerable and oppressed populations, may experience this phenomenon. Bride, Radey and Figley (2007) contend social workers who are aware of their disposition for becoming engulfed in their clients' traumas are more likely to seek help and less likely to experience burnout. However, according to research by Strozier and Evans (1998), while direct practice-oriented social workers advocate for the oppressed and disenfranchised, they often fail to seek treatment for their own physical or mental health needs. Social workers self identify as altruistic helpers. They are prepared and ready to aid

clients, friends and family members, but often leave themselves vulnerable to the same mental and physical health maladies experienced by clients (Siebert & Siebert, 2007).

Like social workers, informal caregivers are also often plagued by chronic stress and are more likely to suffer from declines in their physical and mental health (Fredman, Cauley, Hochberg, Ensrud, & Doros, 2010). Perkins and Haley (2010) conceptualize compound caregivers as lifelong sandwich caregivers who care for children with disabilities and additional elder family members. Like social workers, compound caregivers so completely identify themselves as helpers, they are resistant to seeking help for themselves. This leaves them at risk for negative physical and mental health outcomes (Perkins & Haley, 2010). These authors also assert that the serial nature of compound caregiving, coming in waves, unpredictable in nature, may lead to role overload (Pearlin et al., 1990; Perkins & Haley, 2010). In their study of social workers in California, Kim et al. (2011) connect burnout with negative physical health outcomes. Perhaps most significant for the purpose of this research study, Pearlin, Lieberman, Menaghan, and Mullan (1981) postulate that disparate factors in one's personal and professional life may come together to create a damaging cocktail of chronic stress. It is therefore reasonable that social workers, professional life-long caregivers, who also juggle informal caregiving responsibilities, are at risk to experience negative physical and psychological consequences of their multiple roles. The present research study will expand on the body of literature examining associations among caregiving characteristics, burden of caregiving, depressive symptomology, physical health, self-care, life satisfaction, and social support by surveying social workers and better understanding their unique experiences.

### **Contribution of the Current Study to the Current Body of Research**

This research study contributes to the current body of literature by examining the experience of social workers that also act as informal caregivers. Identification of influential variables aids better understanding regarding the impact of caregiving on social workers' physical health, depressive symptomology, self-care, life satisfaction, and social support. The current study also benefits direct practice by providing social workers and their employers with greater insight regarding the social worker workforce, training issues, and supervision issues. The current study has the potential to profoundly impact social work policy by providing a roadmap regarding human resource policies that may be more responsive to high risk employees, such as those engaged in informal caregiving for adults.

## **CHAPTER 2: REVIEW OF THE LITERATURE**

The purpose of the current study is to examine the interrelationships among social workers caregiving characteristics, burden of caregiving, depressive symptomology, physical health, self-care, life satisfaction, and social support. This review examines current literature primarily published in the fields of sociology, gerontology, psychology and social psychology, that explores role accumulation, and the impacts of caregiving on informal caregivers' and social workers' physical health, psychological stress and life satisfaction. Research investigating the mediating effects of social support, and self-care is also reviewed. There is a gap in the literature regarding the impact of informal caregiving on social workers engaged in direct practice. This gap in the literature will be addressed in this discussion. The review concludes with a summary of the current state of knowledge concerning the impacts of caregiving and how this study addressed some of the identified gaps in knowledge in the literature.

### **Multiple Roles**

This section discusses empirical studies regarding role accumulation in relation to caregiving strain. Demographic information regarding samples, sampling methods, and research designs of these studies are described where relevant. Key findings are also discussed.

### **Multiple Roles and Caregiving**

According to AARP Public Policy Institute (2011) 75% of all informal caregivers maintain employment while also engaged in informal caregiving. Arguments abound in the literature regarding multiple roles and responsibilities being healthful or the cause of damaging stress. In a seminal white paper on role accumulation, Sieber (1974) contends that as individuals take on more responsibilities, they benefit from those roles in the form of advantages, social status, financial rewards and self-esteem. The date and content of Sieber's study suggest he was

focused on the experience of men. Baruch and Barnett (1986) augment Sieber's work adding that women also experience "role enhancement," flourishing mentally and physically when challenged with multiple responsibilities (Baruch & Barnett, 1986, p. 578). Baruch & Barnett (1986) contend that rather than suffering physically and mentally from the stress of multiple roles, women thrive. They are buffered from potentially damaging stress of child rearing and caregiving for aging parents or relatives, by positive reinforcement and professional accomplishment (Baruch & Barnett, 1986). In one caregiving study, Skaff and Pearlin (1992) recognized role enhancement in adult child caregivers who appeared to benefit from responsibilities separate from caregiving. In their study (Skaff, & Perlin, 1992), the number of outside roles caregivers held aside from their caregiving responsibilities was negatively correlated with role strain and loss of self-esteem often associated with chronic caregiving. However, Reid and Hardy (1999) caution that many studies on role enhancement, measuring quantity of roles and their impact on quality of life or well being, fail to examine the type of roles and responsibilities women or men actually occupy. Not every role is exactly the same; thus, researchers may be inadvertently comparing roles that are vastly different (Reid & Hardy, 1999). Hochschild (2012) adds that while working women are mentally challenged and gain self-esteem from multiple responsibilities in and out of the home, they also often suffer physically and psychologically from the strain.

There appears to be a threshold past which expanding roles and responsibilities cause strain. When chronic demands of various roles become overwhelming, or when responsibilities are inharmonious and force the individual to choose between various demands, individuals may experience role strain (Goode, 1960; Reid & Hardy, 1999; Williams, Suls, Alliger, Learner, & Wan, 1991). Most often, it is women, traditional family caregivers, who bear the brunt of the



caregiving burden, taking on informal caregiving for ailing family members in addition to work demands outside the home, child rearing. Hochschild (2012) blamed the relentless balancing act women often attempt to maintain, working full or part time and managing domestic responsibilities, including caregiving, as the catalyst for tipping the scale from fulfilling responsibilities to dangerous stress. Long-term chronic stress is pertinent to the research of Pearlin et al. (1981), who theorize that a single event or a chain of connected events may be the catalyst for damaging stress, exacerbating feelings of role strain, and depressive symptomology. It is expected that the current study will prove that informal caregiving in addition to caring for others at work, as part of the responsibilities associated with direct practice, creates a stress reaction that may negatively impact participants' psychological and physical health.

Waldron, Weiss, and Hughs (1998) utilized data culled from the 1978, 1983, and 1988 National Longitudinal Surveys of Women to examine the health implications for women ( $n=3,331$ ) occupying multiple roles, including motherhood, employment and marriage. They found women's health was not affected even when they accumulated additional responsibilities, including paid employment, marriage and motherhood (Waldron et al., 1998). Pavalko and Woodbury (2000) replicated that study utilizing data from the 1987 and 1989 National Longitudinal Surveys of Mature Women, to determine whether the physical and emotional health of women ( $n=2,929$ ), between the ages of 50-65 years (in 1987) was impacted differently when life roles include informal caregiving. Their research (Pavalko & Woodbury, 2000) showed caregiving had a varying impact on women who were employed. Interestingly, in keeping with theories regarding role enhancement (Baruch & Barnett, 1986), they found that employment buffered participants' health and well being from the strain of informal caregiving. Pavalko and Woodbury (2000) caution that employment may not actually play a mediating role, but instead

afford these women the ability to hire someone to assist with caregiving and household chores. They (Pavalko & Woodbury, 2000) also found that caregiving had a significant negative impact on psychological health of women. Most notably, long-term caregivers suffered from more stress and depressive symptomology (Pavalko & Woodbury, 2000).

### **Informal Caregiving**

This section discusses empirical studies that have examined knowledge about physical and psychological health, and life satisfaction of informal caregivers in the United States. Demographic information about samples, sampling methods, and research designs of these studies are described where relevant. Key findings are also discussed.

#### **Impact of Long-term Informal Caregiving**

##### **Caring for parent or relative with Alzheimer's disease.**

Researchers have considered the diversity amongst caregivers and care recipients to better understand how their varying experiences may impact caregiver welfare (Pearlin, 1992). Much of the research pivots on the stress caused by caregiving and springs from a seminal white paper by Pearlin, Mullan, Semple and Skaff (1990). These authors delineate why caregiving is most profoundly stressful for those who assist spouses, parents or other relatives diagnosed with Alzheimer's disease or related diagnoses, such as dementia. These long-term informal caregivers are particularly at risk for chronic stress as the result of the prolonged nature of their caregiving burden. Skaff and Pearlin (1992) drew data from a survey of caregivers ( $n=527$ ), all members of either the Bay Area or Los Angeles chapters of the Alzheimer's Disease and Related Disorder's Association.

### **Research regarding impacts on caregivers' self esteem and mediating factors.**

Hoping to better understand how long-term caregiving affected caregivers' sense of self, Skaff and Pearlin (1992) utilized a variety of self-developed interviewer questions to gauge self-loss, positive feelings of competency, role engulfment and social isolation. They also measured feelings of self-esteem via an abbreviated version of Rosenberg's Self-Esteem Scale (1965). In addition, the researchers compared the impacts of caregiving on spouses ( $n=310$ ) and adult children ( $n=219$ ) to assess the varying experiences within their sample. LeBlanc, Driscoll and Pearlin (2003) expanded on Skaff and Pearlin's (1992) study by examining not only the physical and psychological affects of caregiving stress, but also potential mediating effects of religion experienced by a convenience sample of informal caregivers ( $n=200$ ) assisting a husband or wife living with Alzheimer's Disease or dementia. All participants lived in the vicinity of Baltimore, Northern Virginia, and Washington, D.C. The majority of the sample was female (62%), non-Hispanic White (89%), and self-identified their religion as Protestant (59%). Other religions represented by sample members included Catholic (23%) and Jewish (12%). Participants were on average 73 years old, and had a mean income of \$46,000 per year. Interestingly, LeBlanc et al. (2003) found that although religion did not moderate feelings of stress felt by caregivers, religiosity positively correlated with participants' feelings of being overwhelmed by too many responsibilities, which was correlated with caregivers' feelings of depressive symptomology. They (LeBlanc et al., 2003) interpret these findings to mean caregivers utilized religion as a means of coping with their own psychological distress.

These latter studies (LeBlanc et al., 2003; Pearlin et al., 1990; & Skaff & Pearlin, 1992) showed that stress experienced by informal caregivers was highly variable, depending on the length and intensity of caregiving, the caregivers' ability to cope, and marshal outside resources

such as social support (Pearlin et al., 1990). What's more, as informal caregiving demands escalate, informal caregivers increasingly shed outside responsibilities, thus becoming more consumed by their caretaking role. According to Skaff and Pearlin (1992) and research by LeBlanc et al., (2004), as caregivers become more isolated they also exhibit greater depressive symptomology, loss of self-esteem and self-efficacy. In contrast, those caregivers who remained employed and retained social lives, seemed to experience a buffer against the most harmful side effects of informal caregiving (Skaff & Pearlin, 1992). Religion, while sometimes employed as a means of coping, did not moderate the impact of caregiving strain (LeBlanc et al., 2004).

### **Incremental effects of multiple caregiving roles.**

Perkins and Haley (2010) examined how incremental responsibilities and longevity of informal caregiving affected the caregiver, conceptualizing compound caregivers as those individuals chronically caregiving for adult children with intellectual or physical disabilities while simultaneously caring for aging parents. Their (Perkins & Haley, 2010) cross-sectional study utilized a convenience sample of middle age caregivers ( $n=91$ ) living in the Tampa Bay area of Florida to compare physical and mental health, depressive symptomology and self-perceived quality of life of caregivers ( $n=57$ ) and those that the researchers classified as compound caregivers ( $n=34$ ). The research was conducted via semi-structured interviews in caregivers' homes or via telephone. Physical and mental health was measured using the Medical Outcomes Study-Short Form (Ware & Sherbourne, 1992). Depressive symptomology was assessed utilizing the Center for Epidemiologic Studies- Depression Scale (CES-D) (Radloff, 1977). The Life Satisfaction Index -Z (Wood, Wylie, & Schaefer, 1969) was used to measure subjective well-being. Contrary to their predictions, Perkins and Haley (2010) found that among compound caregivers, the incremental caregiving responsibilities related to assisting more than

one person (i.e. an adult child and an elderly parent or relative), did not correlate with poor physical health, increased depressive symptomology or lower morale. While it would be unfair to characterize compound caregivers as “stress-free,” the additional load of compound caregiving did not equate to additional stress beyond non-compound caregivers. Instead, compound caregivers expressed feelings of expertise and satisfaction from their caregiving role (Perkins & Haley, 2010). However, compound caregivers interviewed also admitted that there were times when despite being burdened by their caregiving role, they failed to seek assistance (Perkins & Haley, 2010).

### **Impact of personality and lifestyle on caregiving experience.**

Other researchers focused on how the varying characteristics and life styles of caregivers themselves impact the caregiving experience and caregivers self-perceived role strain. In a rare longitudinal study, Fredman, Cauley, Hochberg, Ensrud, and Doros (2010) assembled a convenience sample of elderly women ( $n=1069$ ) enrolled in the Study of Osteoporotic Fractures (Cummings et al., 1990). The researchers followed their sample for 8 years, comparing the physical and mental health implications for those in the sample who were caregivers ( $n=375$ ) and those without caregiving responsibilities ( $n=694$ ). These researchers (Fredman et al., 2010) used the Perceived Stress Scale (Cohen, Kamarck, & Mermelstein, 1983) to measure burden related to caregiving and monitored mortality amongst participants. When comparing caregivers with non-caregivers, Fredman et al. (2010) concluded that stress, not necessarily caregiving was the culprit for higher rates of mortality. The informal caregivers in the sample ( $n=375$ ) actually had lower mortality rates than their non-caregiving counterparts. Löckenhoff, Duberstein, Friedman and Costa (2011), also interested in the interrelationships among caregiving, stress, and health, surveyed a random sample of informal caregivers ( $n=536$ ) over a period of 20 months to

determine how aspects of personality may affect not only self-perception of caregiver strain, but also subjective assessments of competence and physical well-being. Researchers (Löckenhoff et al., 2011) used the NEO Personality Inventory Revised (Costa & McRae, 1992) and an adapted version of the stress process model (Pearlin et al., 1990) to measure caregiving strain.

Löckenhoff et al. (2011) concluded personality traits, including self-efficacy, positively correlated with self-perceived physical health. In other words, caregivers' positive outlook, and belief in their abilities correlated with caregivers' feeling of well-being.

### **Impact of race and ethnicity on caregiving experience.**

A search of the literature yielded three significant studies focused on the caregiving experience in relation to race and ethnicity. Williams, Dilworth-Anderson, and Goodwin (2003) examined the psychological role strain experienced by a random sample of African-American women ( $n=148$ ) living in the Piedmont area of North Carolina; all providing varying levels of assistance to elderly relatives. Williams et al. (2003) utilized the Global Role Strain Scale (Achbold, Steward, Greenlick, & Harvath, 1990) to assess caregiver role strain. In a follow up study, Dilworth-Anderson, Goodwin and Williams (2004) selected a convenience sample of African-American caregivers ( $n=107$ ) from the Piedmont area of North Carolina to examine the longitudinal physical health implications of caregiving and ethnicity. They utilized the stress process model developed by Pearlin et al., (1990). In a third study, Hilgeman et al. (2009) also utilized the stress process model (Pearlin et al., 1990) to better understand how members of various races and ethnic groups are differentially affected by the stress of caregiving and whether race and/or ethnicity mediated the impact of caregiving stress. The researchers examined secondary data culled from the REACH II clinical trial (2004-2006) identifying a racially diverse random sample ( $n=609$ ) from the clinical trial that took place across five American cities

(Birmingham, Memphis, Miami, Palo Alto, and Philadelphia). Members of the sample included caregivers at a minimum age of 21, who were Caucasian ( $n=212$ ), African American ( $n=201$ ), and Hispanic ( $n=196$ ); and who provided a minimum of four hours of informal caregiving per day for at least six months. In each of these three studies, researchers concluded that the caregiver's personality, experience, culture, resources and social support determined the psychological and physical health of the caregiver.

### **Summary of impacts of caregiving.**

The importance of the research conducted by Löckenhoff et al. (2011) on personality traits of caregivers cannot be overstated. Although informal caregiving may negatively impact the physical and mental health of the caregiver, as shown by Pearlin et al., 1990, Löckenhoff et al. (2011) found that resilience and coping skills allow some caregivers to fare better with their caregiving burden. This perhaps sheds light on Perkins and Haley's (2010) findings that concluded incremental caregiving duties do not necessarily result in diminished life satisfaction, physical and mental health. In fact, Perkins and Haley (2010) contend that compound caregivers often gain self-efficacy and feelings of expertise from their compound caring roles. Similarly the three latter studies (Dilworth-Anderson et al., 2004; Hilgeman et al., 2009; Williams et al., 2003) concerned with caregiving in relation to race and ethnicity, found that while stress of caregiving is additive, the caregiver's unique personality, resilience, resources, and social support ultimately determines the caregiver's subjective experience.

### **Social Workers in Distress**

This section discusses empirical studies that have examined knowledge about social workers' physical and psychological health and their propensity to seek help. Demographic

information about samples, sampling methods, and research designs of these studies are described where relevant. Key findings are also discussed.

### **Social Workers in Distress**

Despite the preponderance of research on informal caregiving, there is a gap in the literature regarding social workers working in the field of direct practice also engaged in informal caregiving in their personal lives. The current literature yielded five studies examining psychological distress, burnout, and health of social workers.

Pooler (2008) states that social workers are particularly at risk for stress. They are buffeted by the escalating needs of clients and diminishing resources, while also managing personal stressors such as relationships, children and caring for aging parents. Pooler (2008) selected a random sample of licensed social workers ( $n=215$ ) working in the state of Kentucky to examine social workers' risks for depression, substance use, relationship problems, role identity, and distress utilizing an anonymous Internet-based survey. Most of the participants were female (85.4%), Caucasian (96%) and married (66%), average age 44.5 (Pooler, 2008). Results of the study showed social workers affected by depressive symptomology, substance use, and relationship problems at rates higher than the general U.S. population. Further, social workers reported that identifying as professional caregivers made it difficult for them to ask for support or help (Pooler, 2008).

Strozier and Evans (1998) surveyed a random sample of 668 licensed social workers, all members of the National Association of Social Workers (NASW). The research sought to better comprehend the extent of physical maladies, substance abuse, emotional and psychological distress, and gauge prevalence of help-seeking behaviors among social workers. Respondents' ages ranged between 36 and 55 years. The vast majority (82%) of the sample was female, and



62% were engaged in direct practice. Strozier and Evans (1998) utilized an adapted version of The Social Worker Health Questionnaire developed by Thoreson, Miller, and Krauskopf (1989). Although 17% (114) of the respondents acknowledged issues related to substance use, emotional problems and/or physical illness, due to reliability problems associated with the self-report nature of the survey, the correct proportion was likely closer to 48% (Strozier & Evans, 2011). The impaired social workers were more likely to also express having difficulties in other areas of their professional lives, such as diminished feelings of personal accomplishment, and/or cynicism; and although the social workers sought professional counsel regarding emotional and psychological problems, few sought treatment for issues related to substance abuse (Strozier & Evans, 2011).

Siebert and Siebert's (2007) research also focused on help-seeking behaviors amongst social workers. The researchers (Siebert & Siebert, 2007) randomly selected a sample ( $n=668$ ) composed of members of the NASW's North Carolina Chapter. The sample was composed primarily of Caucasian (89%) females (82%) between the ages of 36 and 55 years (62%). Siebert and Siebert (2007) developed several of their own measures to assess role identity and help seeking behaviors. Impairment was measured by asking participants to respond to a single statement, "I have worked when I was too distressed to be effective," which was used by Pope, Tabachnick, and Keith-Spiegel (1987). Depressive symptomology was evaluated via the CES-D scale (Radloff, 1977), and burnout was measured using a subscale of the Maslach Burnout Inventory (Maslach & Jackson, 1986). Siebert and Siebert (2007) found that while depressive symptomology often prompted social workers to seek help, the social workers continued to work despite feelings of burnout, or personal distress. In addition, experience in the field of social work did not correlate with help seeking (Siebert & Siebert, 2007).

A study by Adams, Boscarino, and Figley (2006) utilized a random sample ( $n=236$ ) of licensed social workers living in New York City who were members of NASW. The sample was primarily female (80%), Caucasian (89%), with most respondents in a committed relationship (63%) and over the age of 50 (80%). The vast majority of the sample had been involved in counseling individuals affected by the terrorist attack on New York City on September 11, 2001. Adams et al. (2006) were interested in correlations among compassion fatigue, burnout, and social support, having sufficient information for effective work conditions, and sense of mastery. Researchers found compassion fatigue and burnout were positively correlated, but negatively correlated with the other three variables, leading them to conclude that an unsupportive work environment may negatively impact work performance, exacerbate burnout, compassion fatigue and ultimately long term social worker effectiveness (Adams et al., 2006).

Also focused on social worker health, Kim et al. (2011) conducted a three-year longitudinal study to examine the impacts of social worker burnout on physical health. Kim et al. (2011) used a random sample of licensed social workers, working in the State of California. The researchers measured social worker physical health utilizing the Physical Health Questionnaire (PHQ), a 14-item Likert-type scale developed by Schat, Kelloway, and Desmaris (2005). The PHQ allowed Kim et al. (2011) to consider social workers' subjective assessment of sleep, headaches, respiratory infections and gastrointestinal distress. Participants' burnout was measured via the Maslach Burnout Inventory—Human Service Survey (MBI-HSS) as developed by Maslach and Jackson (1986). MBI-HSS, a 22-item scale, that defines burnout according to the following characteristics: physical fatigue, as well as feelings of being psychologically and emotionally drained, extreme negativity, and diminished professional self-esteem (Maslach, Schaufeli, & Leiter, 2001). Although Kim et al. (2011) did not control for the potential influence

of personal life stressors, the researchers concluded burnout negatively affected social workers' physical health.

### **Stress, Compassion Fatigue and Self-Care Among Social Workers**

This section discusses empirical studies and white papers that have examined chronic stress, compassion fatigue and self-care practices among social workers. Demographic information about samples, sampling methods, and research designs of these studies are described where relevant. Key findings are also discussed.

#### **Self-Care as a Buffer for Compassion Fatigue Among Social Workers**

According to seminal research by Pearlin et al. (1981) stress may originate from one unique event or may be the result of chains of events that create sustained stress over longer periods of time. Stress may manifest as the result of personal circumstances or professional angst. Whatever the cause, the body's physiological and psychological response is the same (Pearlin et al., 1981). Of primary concern, chronic, inescapable stress may cause diminished self-efficacy and self-esteem (Pearlin et al., 1981). Social workers, by nature of their work with disadvantaged populations, are at risk for experiencing not only professional stress that comes from employment, but also what Figley (1995; 2002) defines as compassion fatigue. Compassion fatigue, also known as secondary traumatic stress, is the toll many social workers experience as the result of caring for others within the scope of direct practice (Figley, 1995; 2002). As the therapist empathizes with the client, especially over long periods of time, the client's pain may invade the therapist's psyche (Figley, 2002).

Consistent with the research by Pearlin et al. (1981) regarding manifestations of stress, Adams, Figley, and Boscarino (2008) contend that stress in the form of compassion fatigue may result in negative psychological outcomes for the social worker. Adams et al. (2008) examined

what factors might exacerbate or mediate compassion fatigue and burnout, and whether compassion fatigue was predictive of job burnout. The researchers surveyed a random sample ( $n=236$ ) of licensed social workers living in New York City who were members of NASW. The majority of respondents was female (80%), Caucasian (89%), over age 50 (80%), and reported more than 20 years of experience in the field of social work direct practice. Compassion fatigue and burnout were measured utilizing an adapted version of the CF Scale-Revised developed by Gentry, Baranowsky, and Dunning (2002). Psychological health and distress was measured using the 12-item version of the General Health Questionnaire (GHQ-12) developed by Goldberg and Huxley (1992). Adams et al. (2008) found that while different stressors cause burnout and compassion fatigue, both conditions may result in psychological distress for the social worker. In addition, the researchers (Adams et al., 2008) found social workers who had social support in the form of intimate relationships and perceived a supportive work environment showed lower job burnout, greater self-esteem and over all better outlook.

According to a policy statement issued by NASW (2000), self-care is integral to ethical social work practice. Pooler (2008) contends social workers should be formally prepared, at the undergraduate or graduate school level, to expect and better manage the stressful nature of the profession. A review of the literature however, resulted in no empirical studies on the topic of self-care, but did yield a number of white papers on the subject. Pearlin et al. (1981) contend that while individuals may not always manage the amount of stress they experience or when they experience it, they may effectively manage their psychological, emotional, and even physiological responses.

Radey and Figley (2007) are in agreement: These authors assert that stress, such as compassion fatigue, may be moderated through a combination of positive outlook, resources,

including social support, and actively engaging in self-care. According to Radey and Figley (2007), positive outlook may include innate feelings of being grateful, optimism, and happiness. It is the exact opposite of negativity and cynicism that may exacerbate the stress response and interfere with social workers' ability to effectively and ethically serve clients' (Maslach et al., 2001). According to Hesse (2002) personal and professional social support is critical for mediating stress and combating compassion fatigue. Hesse (2002) further postulates that supervision, supportive colleagues, and continuing education are necessary not only for professional skills development, but also for social workers' sustained mental health and therefore effective practice. Figley (2002) believes social workers may best manage professional stress, including compassion fatigue, through participating in reciprocal personal relationships, volunteering, and psychotherapy. Radey and Figley (2007) identify self-care as a critical means of improving both one's affect and augmenting personal support systems. While self-care is wholly individual, it should include activities that diminish physical and psychological effects of stress (Radey & Figley, 2007), including attention to spiritual, mental and emotional, physical, and social activities (Moore, Bledsoe, Perry & Robinson, 2011).

### **Limitations of Empirical Investigations**

The major limitations of the studies described in this literature review include reliance on cross-sectional designs, threats to generalizability to the larger population due to the source, or collection of data, and validity of self-report measures.

### **Limitations of Cross-Sectional Design**

With the exception of five longitudinal studies (Dilworth-Anderson et al., 2004; Fredman et al., 2010; Kim et al., 2011; Pavalko & Woodbury, 2000; Waldron et al., 1998) all other research discussed in this literature review used cross-sectional design. According to Rubin and

Babbie (2010), cross-sectional studies are essentially flawed because prevalence and interrelationships among variables are based on one moment in time. As a result, the vast majority of reviewed studies are static, and therefore not able to measure change associated with variables. Despite using longitudinal design, Kim et al. (2011), and Dilworth-Anderson (2004) note the three-year length of their respective studies was not long enough and as a result limited their respective abilities to fully establish causality.

### **Limitations Due to Sources of Data**

Longitudinal studies by Waldron et al. (1998) and Pavalko and Woodbury (2000) have limitations due to the sources of their data. Both studies (Waldron et al., 1998; Pavalko & Woodbury, 2000) utilize secondary data from the National Longitudinal Surveys of Women. While using multiple years of data allowed the researchers to avoid the pitfalls of cross-sectional design, Rubin and Babbie (2010) note that secondary data is not without problems, such as older or missing data, limiting validity and reliability.

### **Limitations Due to Representativeness of Sample**

External validity of research may be compromised by researchers' inability to generalize their research to the greater population (Rubin & Babbie, 2010). The bulk of the 16 reviewed quantitative studies used small sample sizes that were not randomly selected. Seven of the research studies included fewer than 250 participants (Adams et al., 2006; 2008; Dilworth-Anderson et al., 2004; LeBlanc et al., 2003; Perkins & Haley, 2010; Pooler 2008; Williams et al., 2003). Generalizability may also be jeopardized due to non-representativeness of the sample, as when participants are drawn from a pool that does not necessarily approximate the characteristics of the greater population (Rubin & Babbie, 2010). Löckenhoff et al. (2011) note that although their sample was representative of the population in question, it was not representative of the full

ethnic and racial diversity of the United States. Nine studies (Adams et al., 2006; 2008; Kim et al., 2011; LeBlanc et al., 2003; Perkins & Haley, 2010; Pooler, 2008; Siebert & Siebert, 2007; Skaff & Pearlin, 1992; Williams et al., 2003) included in this review, sampled individuals living in a limited geographical area. In addition, each of the five studies (Adams et al., 2006; 2008; Kim et al., 2011; Pooler, 2008; Siebert & Siebert, 2007; Strozier & Evans, 2011) that sampled social workers utilized the NASW membership. Not all social workers are members of NASW, thus, researchers risk biasing their results by limiting their samples to only those social workers that choose membership in NASW (Adams et al., 2006).

Generalizability to the larger population may also be compromised as the result of researchers employing non-probability sampling methods (Rubin & Babbie, 2010). While probability sampling remains the ideal in terms of limited resources and being able to list all members of a population (Rubin & Babbie, 2010), oftentimes it is not a reality for researchers who must instead rely on convenience samples (Rubin & Babbie, 2010). Such is the case with five research studies (Fredman et al., 2010; LeBlanc et al., Perkins & Haley, 2010; Skaff & Pearlin, 1992; Williams et al., 2003) included in this literature review. Lack of appropriate diversity may also limit representativeness of samples. For example, LeBlanc et al. (2004) note that their study their research sample was overwhelmingly Caucasian, non-Hispanic, and included individuals of advanced age. Other studies also utilized samples lacking representational diversity (Adams et al., 2006; 2008; Fredman et al., 2010; Hilgeman et al., 2009; Kim et al., 2011; Löckenhoff et al., 2011; Perkins & Haley, 2010; Siebert & Siebert, 2007; Strozier & Evans, 2010).

Attrition may similarly jeopardize a research study's external validity because data collection may be biased towards subsets of the original sample population therefore limiting

researchers ability to draw appropriate comparisons and conclusions from their data (Rubin and Babbie, 2010). Kim et al.'s (2011) longitudinal study of social workers in California is an example of such a study. Their baseline sample shrank by 30% when the researchers surveyed participants a second time. The third phase of the study similarly lost participants. Despite attrition, Kim et al. (2011), contend that the samples in the second and third phases of their study retain similar representation to the initial sample ( $n=406$ ) and therefore the research retains its external validity.

Several studies (Adams et al., 2006; 2008; Pooler, 2008; Strozier & Evans, 2010) also suffered from survey response rates below 50%. Rubin and Babbie (2010) advise response rates below 50% limit the representativeness of the sample. Interestingly, each of these studies included samples of social workers. Strozier and Evans (2010) speculate social workers, some of whom are in personal and professional stress are perhaps less likely to complete research surveys.

### **Limitations Due to Self-Report Measures**

Each of the studies included in this literature review relies on self-report measures. While self-report measures are effective due to ease of implementation (i.e. they are relatively inexpensive and quick to administer), they may lack validity due to participants potentially providing answers based on social desirability rather than truthfulness (Rubin & Babbie, 2010). Perkins and Haley (2010) defend the 13-item short form version of the Life Satisfaction Index Z, a self-report measure, as having internal consistency shown by a reliability coefficient of .77. Löckenhoff et al. (2011) assess caregiver multi-domain self-efficacy with a Likert-type self-report scale developed by Rodin and McAvay (1992), which has only moderate levels of consistency ( $\alpha=.60$ ). Löckenhoff et al. (2011) also utilize the NEO Personality Inventory



Revised, developed by Costa and McCrae (1992), despite the fact that this scale has varying reliability due to the possibility that respondents do not respond truthfully. Nonetheless, the researchers point to the scale's consistent use and validity across studies with varied samples as testament of its reliability (Löckenhoff et al., 2011). Strozier and Evans (2011) assess social worker demographics, general emotional and physical health, substance use and help-seeking patterns using the 60-item Social Worker Health Questionnaire. The researchers (Strozier & Evans, 2011) note the measure's sub-scales have moderate to high internal reliability and consistency. However, despite reporting 17% (114) of their sample ( $n=668$ ) suffered from substance use, mental or physical health maladies, Strozier and Evans (2011) believe the actual percentage to be closer to 48%. This difference they attribute to participants denial regarding their compromised health and distress.

### **Summary and Implications of Literature Review**

This literature review examines empirical and conceptual research to explore the complexities of role accumulation, the risks and mediating factors of caregiving on the physical and mental health of informal caregivers and professional social workers.

Informal caregiving may progress from a short term, relatively innocuous responsibility, to an all-consuming long-term occupation that results in loss of balance between caregiving roles and outside responsibilities (Pearlin, 1990). While outside responsibilities may buffer caregivers self esteem (Skaff & Pearlin, 1992), managing escalating caregiving responsibilities with demands of employment, frequently results in informal caregivers suffering from negative impacts on their personal and professional lives. These include chronic medical conditions, such as depression and hypertension, as well as decreased productivity, job performance and disruptions to their careers (Albert & Schulz, 2010; Giovannetti et al., 2009; NAFC & the

National Center on Women and Aging at Brandeis University, 1999). Unfortunately, little is known about social workers in direct practice who also take on informal caregiving responsibilities. However, we may infer that social workers, like other professionals, may similarly struggle to balance informal care roles with profession job demands.

This study adds to the knowledge base by examining the role of compassion fatigue, an important variable in related research related to social workers. Caring for vulnerable clients, social workers often experience compassion fatigue, the unrelenting stress of empathizing within the scope of direct practice (Figley, 1995; 2002). Unfortunately, social workers' self image as helpers, in and out of the workplace, makes them more likely to take on additional caring roles, while at the same time apparently unable to see their own impairment and seek support (Pooler, 2008; Siebert & Siebert, 2007; Strozier & Evans, 1998). This aversion to help seeking may put social workers, who also engage as informal caregivers, at especially high risk for physical health impediments, depressive symptomology, and lower life satisfaction. This research study, therefore, collects information about respondents' psychological and physical health, and life satisfaction, critical variables in determining the impact of informal caregiving on the social work workforce.

The present study also investigates the role of variables that may moderate stress. Social support, as well as interests and responsibilities separate from caregiving appear to mediate the stress and loss of self-esteem experienced by many informal caregivers (Löckenhoff et al., 2011; Pearlin et al., 1990; Skaff & Pearlin, 1992). Similarly, Figley (2002) and Radey and Figley (2007) expound on self-care as critical to the health and well being of the social worker workforce. Pursuing outside interests, relationships, physical fitness, or social activities allow social workers to relieve their stress and replenish their energy and ability to effectively advocate

and care for clients (Hesse, 2002). However, according to Siebert and Siebert (2007) knowing how to alleviate stress, and actually engaging in those activities are not equated. This study seeks to understand respondents' self-care routines in order to provide educators and employers with critical information to safeguard the health and well-being of the current and future social worker workforce (Pooler, 2008).

There is a gap in the literature examining negative psychological and physical impacts on direct practice social workers who also have informal caregiving responsibilities. The current study provides insight into the effects on social workers engaged in informal, as well as professional caregiving and the consequences of engaging in these dual roles. Identification of influential variables will bolster knowledge regarding the impact of caregiving on social workers' burden of caregiving, depressive symptomology, physical health, self-care, life satisfaction, and social support. The current study may also inform practice by providing social workers and their employers with greater insight regarding the social worker workforce, training issues, and supervision issues. The current study also has potential to positively impact agency policy by providing a roadmap regarding human resource policies that may be more responsive to high-risk employees, such as those engaged in informal caregiving for adults over the age of 18.

## **CHAPTER 3: CONCEPTUAL FRAMEWORK**

### **Purpose**

This descriptive cross-sectional research study examined the interrelationships among social workers' caregiving characteristics, burden of caregiving, depressive symptomology, physical health, self-care, life satisfaction, and social support. It was conducted via an anonymous Internet-based survey instrument.

### **Research Hypotheses**

The current study investigated the following hypotheses:

1. Burden of caregiving is positively correlated with depressive symptomology.
2. Amongst social workers, the burden of caregiving is negatively correlated with physical health, self-care and life satisfaction.
3. Amongst social workers with additive caregiving characteristics, social support is positively correlated with both self-care and life satisfaction.

### **Definitions of Key Terms**

This section defines key terms in the current research study. Specific instrumentation for measuring key concepts may be found in the Methodology section.

#### **Caregiving**

Caregiving includes the concepts a) informal caregiving, b) professional caregiving, and c) additive caregiving.

- a. Informal caregiving refers to providing unpaid assistance to an individual over the age of 18 years in his/her own home (NAFC & AARP, 2009). Informal caregiving status was determined through participants' response to researcher-developed question "Do you

currently have unpaid caregiving responsibilities for an individual over the age of 18 years of age?”

- b. Professional caregiving pertains to those social workers engaged in direct practice with clients as part of their occupational responsibilities. Professional caregiving was determined through social worker yes or no response to the question “Is direct practice part of your current or most recent job description as a social worker?”
- c. The variable, additive caregiving refers to those social workers, engaged in direct practice, who have responsibility for the care of children under the age of 17, and informal unpaid caregiving responsibilities for adults over the age of 18. Additive caregiving was measured by caregiver response to the questions “Is direct practice part of your current or most recent job description as a social worker?” and “Do you currently have unpaid caregiving responsibilities for an individual over the age of 18 years of age?” Additive caregiving was further assessed with researcher-developed questions related to childcare responsibilities. Questions included: “How many children, age 17 or younger, live in your household?” To measure parenting strain, the 6-item self-report Family Strain Index was included to assess parenting strain in relation to other variables (Riley et al., 2006).

### **Burden of Caregiving**

Burden of caregiving refers to the hours devoted to caregiving, and the length of time engaged in a caregiver role. Burden of caregiving also includes the perceived strain experienced by the caregiver as the result of providing assistance with Activities of Daily Living (ADLs), personal care tasks, such as dressing, bathing, toileting, eating, grooming, and Instrumental Activities of Daily Living (IADLs) such as transportation, house keeping, obtaining and preparing meals,

managing healthcare, insurance, and other services (NAFC & AARP, 2009). Burden of caregiving was measured utilizing the brief, self-administered Modified Caregiver Strain Index (CSI) developed by Thornton and Travis (2003) to assess caregivers' perceived level of strain.

### **Depressive Symptomology**

Depressive symptomology includes the diagnostic criteria that comprise a Major Depressive Episode (MDE) as defined by the DSM-IV-TR as feelings of melancholy and having a downcast mood, failure to enjoy formerly interesting activities, loss of appetite, insomnia, psychomotor agitation (such as wringing of hands) or slowing of typical physical movement, continual feelings of being tired despite rest, feelings of guilt, inability to make a decision, difficulty concentrating, thoughts of suicide (APA, 2000). Five out of these nine criteria must be present for a diagnosis of MDE (APA, 2000). Depressive symptomology was measured with the CES-D Scale, a 20-item self-report instrument developed to assess duration and intensity of depressed mood in relation to other variables (Radloff, 1977).

### **Physical Health**

Physical health refers to the body operating normally, or as it is intended. Dilworth-Anderson et al. (2004) conceptualize perceived physical health as an ostensible measure of general physical health and functioning. In this study, caregivers' perception of their physical health was measured utilizing the Healthy Days Core Module (CDC HRQOL-4), a 4-item questionnaire that allows respondents to rate their perceived level of general physical health (CDC, 2000).

### **Self-Care**

Self-care includes activities social workers consciously engage in with the purpose of relieving the stress resulting from helping and listening to clients (Moore et al., 2011). Self-care activities may include mindfulness, meditation, exercise, eating well, as well as other measures to ensure

physical and emotional well-being (Radey & Figley, 2007). Self-care is prescribed for social workers to avoid compassion fatigue as well as physical and emotional exhaustion, often referred to as burnout (Moore, Bledsoe, Perry & Robinson, 2011). The level of participation in self-care activities was measured with a modified version of the Self-care Assessment that measures the number and types of self-care activities (Saakvitne & Pearlman, 1996).

### **Life Satisfaction**

For the purpose of this study, life satisfaction refers to a sense of self-reported fulfillment and level of happiness gained from personal and professional roles (Perkins & Haley, 2010). Life satisfaction was measured with the Satisfaction with Life Scale, a 5-item self-report instrument developed to assess general life satisfaction (Diener, Emmons, Larsen, & Griffin, 1985).

### **Social Support**

For the purpose of this study, social support was defined as social resources, including friends, family members, professional mentors and supportive colleagues that together allow social workers to professionally thrive (Radey & Figley, 2007). Social support was measured with the Multidimensional Scale of Perceived Social Support, a short, self-report instrument for determining quantity and quality of perceived support (Zimet, Dahlem, Zimet, & Farley, 1988).

## CHAPTER 4: METHODOLOGY

The purpose of this cross-sectional descriptive research study was to examine the interrelationships among social workers' caregiving characteristics, burden of caregiving, depressive symptomology, physical health, self-care, life satisfaction and social support.

The current research study utilized a sample of Licensed Clinical Social Workers practicing in Louisiana. Surveys were sent to 1,869 individuals, recruited through the Louisiana State Board of Social Work Examiners' (LBSWE) database, using an availability sampling method. Surveys were completed by approximately 35% ( $n=657$ ) of the sample, with 120 participants making up the study sample. While a survey response rate of over 50% would typically be desirable, Nulty (2008) points out that online surveys achieve average response rates of 33%, significantly lower than paper-based surveys. Manfreda, Bosnjak, Berzelak, Haas, and Vehovar (2008) concur, noting that online surveys typically achieve lower response rates. Among the 657 participants who completed this survey, 121 reported experiences as caregivers. The researcher made an executive decision to eliminate one participant because of irregularities in his/her survey answers. Due to the use of a purposive sample, the results from the current study are generalizable to only Licensed Clinical Social Workers (LCSW) working in Louisiana, and to those with similar professional and personal characteristics within the southeast region of the United States.

According to Rubin and Babbie (2010), samples of 80 to 100 participants allow the researcher to obtain sufficient level of power (.83-.86), at a level of significance of .05, to detect a medium effect size (.60). This study achieved an adequate sample to ensure sufficient power for bivariate analysis of data.



### **Protection of Human Subjects**

The procedures for the collection of data in the current study allowed participants to remain anonymous. The data was collected using a voluntary, self-report, Internet-based survey instrument. Participants were not compensated for their participation. Written information about the study was provided at the beginning of the survey. The written script notified participants that they provided their informed consent by completing the survey. No identifying information was collected from participants. Risk of harm to participants was minimal; thus this research was granted an exemption from Institutional Review Board oversight (see Appendix for IRB approval).

### **Design and Procedure**

This descriptive research study was undertaken with social workers and utilized a cross-sectional design to examine correlations among variables, including caregiving characteristics, burden of caregiving, depressive symptomology, physical health, self-care, life satisfaction, and social support. The survey instrument was pretested with a comparable subsample of social workers to ensure that items were clearly worded, and leading questions and loaded words were eliminated. The survey instrument was composed of self-report measures. While using a self-report instrument is effective due to ease of implementation, it may jeopardize validity due to participants potentially providing answers based on social desirability rather than truthfulness (Rubin & Babbie, 2010). Issues related to external validity that may have impacted the representativeness of this research include the employment of non-probability sampling methods, selection bias including race and gender. This may result in a lack of sufficient diversity and therefore limit representativeness of the sample (Rubin & Babbie, 2010).

## **Measurement**

This study examined interrelationships among social workers' caregiving characteristics, burden of caregiving, depressive symptomology, physical health, self-care, life satisfaction, and social support using a combination of existing scales and researcher-developed items. Caregiving characteristics assess participants' self-reported involvement in informal caregiving activities, parenting and professional direct practice through researcher developed questions and the 6-item Family Strain Index (Riley et al., 2006). Burden of caregiving refers to the degree of self-perceived strain participants experience from informal caregiving. Depressive symptomology was measured with an existing 20-item self-report instrument to assess duration and intensity of depressed mood (Radloff, 1977). Burden of caregiving was defined by hours devoted to informal caregiving, and length of time engaged in a caregiving role. Burden of caregiving was measured utilizing a brief, self-report instrument to assess caregivers' perceived strain. General physical health refers the state of being free from physical or mental injury or distress. A 4-item questionnaire was utilized to gauge respondents' perception of their general physical health. The level of participation in self-care activities was assessed with self-report instrument regarding frequency and types of self-care activities. Life satisfaction was measured with a 5-item, self-report instrument developed to assess global life satisfaction. Social support was conceptualized as social resources, including friends, family members, professional mentors and supportive colleagues that together allow social workers to professionally thrive (Radey & Figley, 2007). Social support was measured with a short self-report instrument to determine quality and quantity of perceived support (Zimet, Dahlem, Zimet, & Farley, 1988).

## **Instrumentation**

A 28-item composite survey instrument composed of researcher-developed items and existing survey instruments was used to assess participants' caregiving characteristics, burden of caregiving, depressive symptomology, physical health, self-care, life satisfaction, and social support.

### **Caregiving Characteristics**

The caregiving items consisted of 5 researcher-developed questions used to establish the extent of respondents' caregiving responsibilities. Items included questions related to the nature of caregiving responsibilities, relationship of caregiver to care recipient, number of caregiving hours provided per week, number of children and grandchildren living in the household, and whether any of those children had special needs. In addition, caregiving was assessed with the Family Strain Index (FSI) (Riley et al., 2006). FSI is a 6-item self-report instrument that measures strain experienced by parents using a 5-point Likert scale. Response options included *never*, *almost never*, *sometimes*, *almost always*, and *always* (Riley et al., 2006). The range of scores is 0 to 24, with higher scores indicating greater levels of strain (Riley et al., 2006). The scale has been shown to have high levels of internal consistency (Cronbach's alpha of .87), and has been determined to be a valid instrument for assessing self perceived stress of parents' whose children have been diagnosed with ADHD (Riley et al., 2006).

### **Burden of Caregiving**

The self-administered Modified Caregiver Strain Index (CSI) was utilized to measure burden of caregiving (Thornton & Travis, 2003). This scale consists of 13 items designed to gauge long-term strain related to providing care to adults over the age of 18. Participants were given three response choices for each item: *yes*, *sometimes*, and *no*. Responses were scored as 2

points for each “yes” response, 1 point for each “sometimes” response, zero points for each “no” response. The possible range of scores is 0 to 28, with higher scores indicating a greater degree of strain experienced by the participant. Thornton and Travis (2003) report that CSI has high internal reliability coefficient of .90. The measure also performed well on test-retest reliability, yielding a coefficient of .88 (Thornton & Travis, 2003).

### **Depressive Symptomology**

Depressive symptomology was measured using the 20-item CES-D Scale, which was developed to assess the duration and intensity of depressed mood in relation to other variables (Radloff, 1977). Participants were asked to rank their level of agreement with each item using a 4-point Likert scale. Response options include *rarely or none of the time, some or a little of the time, occasionally or moderate amount of time, most or all of the time* (Radloff, 1977). The possible range of scores is 0 - 60, with higher scores indicating greater depressive symptomology, defined as occurring more frequently during the past seven days (Radloff, 1977). Measures of internal consistency viz. coefficient alpha and split halves method were high in both general and patient populations, at  $\alpha=.85$  and  $\alpha=.90$ , respectively (Radloff, 1977). The CES-D Scale also performs well on test-retest, measures of concurrent validity, self-report criteria, and shows construct validity (Radloff, 1977). Finally, the CES-D has been demonstrated to be generalizable across demographic subgroups including age, race, and levels of education (Radloff, 1977).

### **Physical Health**

Physical health was measured using a 4-item questionnaire based on the Healthy Days Core Module (HRQOL-4) designed to assess participants’ perceived level of general physical health (CDC, 2000). The scale provides an estimate of the number of days, during the previous

month, that the participant felt his/her general physical or mental health declined. The first question of this scale requests participants to rate their health using to a 5-point Likert scale, with response options including *excellent*, *very good*, *good*, *fair*, and *poor*. In addition, three items that ask participants the approximate number of days, during the past 30 days, that they experienced declines in physical and mental health, which may have kept them from engaging in usual activities. Scores are calculated by summing the total number of unhealthy days. The possible range of scores is 0 - 30 (CDC, 2000). The HRQOL-4 has been shown to have good internal reliability, correlation with other scales (e.g., SF-36), test-retest reliability, and acceptable construct validity (CDC, 2000).

### **Self-Care**

The self-care scale is based on the Self-Care Assessment developed by Saakvitne, Pearlman, and Staff (1996). The scale asks participants to rate their degree of involvement in 75 self-care activities according to a 4-point Likert scale. Response options include *never*, *rarely*, *occasionally*, or *frequently*. Self-care activities are grouped according to physical, psychological, emotional, spiritual, relationship, professional, and overall balance items. Each sub-scale consisted of 10-15 items, with the exception of the balance scale, which contained 2 items. The researcher made a managerial decision to eliminate redundancy and all double- and triple-barreled questions included in original scale. The revised and abbreviated scale included 20 items. The possible range of scores is 20-80.

### **Life Satisfaction**

Life satisfaction was measured utilizing the 5-item Satisfaction with Life Scale (Diener, Emmons, Larson, & Griffin, 1985). Participants are asked to rank their agreement with each item using a 7-point Likert scale: 1=strongly disagree, 2=disagree, 3=slightly disagree, 4=neither

agree or disagree, 5=slightly agree, 6=agree, 7=strongly agree (Diener et al., 1985) The possible range of scores is 5 to 35 with higher scores indicating more positive attitudes with many aspects of their lives. Diener et al. (1985) reported the Satisfaction with Life Scale performed well on tests of reliability and sensitivity. At least five other researchers have confirmed these latter findings, showing coefficient alphas ranging from .79 to .89, and test-retest stability coefficients of .50 to .84. (Diener et al., 1985). The Satisfaction with Life Scale has been demonstrated to show acceptable construct validity and correlations with other measures of life satisfaction have been acceptable (Pavot & Diener, 1993).

### **Social Support**

A 12-item social support scale was used to measure perceived social support. The Multidimensional Scale of Perceived Social Support examines self-perceived social support as a mediating factor for stress (Zimet et al., 1988). Participants were asked to rank their degree of agreement with each of the 12 statements, using the following 7-point Likert scale: *1=Very Strongly Disagree, 2=Strongly Disagree, 3=Mildly Disagree, 4=Neutral, 5=Mildly Agree, 6=Strongly Agree, 7=Very Strongly Agree* (Zimet, Dahlem, Zimet, & Farley, 1988).. The Multidimensional Scale of Perceived Social Support has yielded a Cronbach's coefficient alpha of .88 showing good internal reliability and shows adequate construct validity (Zimet et al., 1988). Participants were asked to write the relationship of up to five people on whom they may rely for support. This latter researcher-developed item was based on the Purdue Social Support Scale, a self-report instrument for determining quantity and quality of perceived social support (Burge & Figley, 1987). This information regarding the source of social support was measured on the nominal level.

## **Socio-Demographic Characteristics**

Demographic information was collected with questions regarding participants' age, race, and gender. Education and work characteristics were measured with 8 items asking information about participants' job description, employment status, place of employment, job title, years of experience, and level of education attained. An additional item asked respondents about their relationship status.

## **Data Analysis**

Univariate statistics viz., mean, median, and mode were used to obtain frequencies and to summarize data, and bivariate analyses were conducted to examine relationships among measures of caregiving characteristics, burden of caregiving, depressive symptomology, physical health, self-care, life satisfaction, and social support among social workers. Pearson's product moment correlation coefficient ( $r$ ) was used to examine the relationships among variables measured at the interval and ratio levels (Rubin & Babbie, 2010). Correlations were considered significant when the  $p$ -value is .05 or less (Rubin & Babbie, 2010). Independent  $t$ -tests were used to determine differences between male and female (Rubin & Babbie, 2010). Data were analyzed using the Statistical Package for the Social Sciences<sup>TM</sup>.

## **Summary**

The NAFC and AARP (2009) reported that 20% of American adults are providing long-term care for parents, relatives or friends. This percentage of the population involved in informal caregiving is expected to incrementally along with the aging American population (Talley & Crews, 2007). For social workers, already stressed by the burden of their workplace, informal caregiving represents an additive caregiving load that may affect their psychological and physiological well-being. This research study will contribute to the current knowledge base by

examining the experience of social workers who also act as informal caregivers. Identification of influential variables will aid better understanding regarding the impact of caregiving on social workers' depressive symptomology, physical health, self-care, life satisfaction and social support. Hypotheses included: It was expected that caregiving would be positively correlated with depressive symptomology. Further, among social workers, the burden of caregiving would be negatively correlated with physical health, self-care and life satisfaction. Finally, amongst social workers with additive caregiving responsibilities, social support would be correlated with both self-care and life satisfaction.

In terms of practice implications, the findings of the present study may provide social workers and their employers with greater insight regarding caregiving demands experienced by a segment of the social worker workforce thus yielding recommendations for training and supervision. The current study has the potential to impact social work policy by informing the development of human resource policies that may be more responsive to high-risk employees, such as those engaged in caregiving for parents and relatives.



## **CHAPTER 5: RESULTS**

This research examined interrelationships among social workers' caregiving characteristics, burden of caregiving, depressive symptomology, physical health, self-care, life satisfaction and social support. Surveys were distributed via email to 1,869 Licensed Clinical Social Workers (LCSW) practicing in a southern state. Just over one third completed the survey ( $n=657$ ), a response rate of 35%. Although a response rate of at least 50% is desirable (Rubin & Babbie, 2010) for a survey, Nulty (2008) points out that Internet-based surveys, such as the one utilized with this research, yield an average response rate of 33%, which is notably lower than that of paper-based surveys. Among the 657 LCSWs who completed the survey, the final study sample consisted of 120 survey respondents (18.4%) who reported current experience with unpaid informal caregiving. Thus, 6% of LCSWs surveyed in the current study comprised the final study sample.

### **Demographic Characteristics**

The sample was composed of primarily middle-aged white women. Over three fourths were female ( $n=94$ , 78%), and the majority of respondents were Caucasian ( $n=103$ , 86%). The remaining respondents were African American ( $n=16$ , 13%). Participants' ages ranged from 32 to 79 years old, and were, on average, 56 years old ( $SD=9.42$ ). Seven participants did not report their age.

### **Employment and Education Characteristics**

The study sample was composed of social workers who had earned a Master's Degree in Social Work (MSW). Over three fourths of participants reported the MSW as their terminal degree ( $n=93$ , 77.5%), with the rest of respondents reporting that they had earned a post-graduate certificate ( $n=11$ , 9%) or doctoral degree ( $n=14$ , 12%). Two participants did not provide data

regarding their highest level of education. Participants reported an average of 23 years, 6 months of social work experience ( $SD = 9.91$  years). Experience ranged from a minimum of 3 years to a maximum of 45 years, 11 months. One participant did not report amount of social work experience. Just over half of respondents worked full time (40 hours or more) as a social worker ( $n=62$ , 52%), with under one-fourth ( $n=26$ , 22%) working fewer than 40 hours. Nine respondents indicated that they had multiple jobs, working in both a social work and non-social work capacity (8%), and four respondents indicated employment in a field other than social work (3%). Just over 10% of participants were either unemployed or retired ( $n=17$ , 13%). Two participants did not provide data regarding their employment status. The majority of participants indicated that they worked in direct practice social work ( $n=96$ , 80%). Over half were therapists or counselors ( $n=66$ , 55%), while fewer than one fifth were working as administrators ( $n=22$ , 18%), and 12 respondents (11%) reported working in a variety of capacities (viz., client advocate, client educator, researcher, community practitioner, school or university educator, or forensic social worker). The smallest proportion of participants ( $n=11$ , 9%) in direct practice reported working as case managers. Nine participants did not report their job function.

### **Caregiving Characteristics**

Participants comprising the final study sample ( $n=120$ ) provided informal, unpaid, care for an individual over the age of 18. Over half of all respondents indicated that they provide informal care for a parent ( $n=61$ , 51%). Others reported providing care to adult children ( $n=31$ , 26%), relatives ( $n=10$ , 8%), spouses ( $n=6$ , 5%), friends ( $n=4$ , 3%), or ex-spouses ( $n=2$ , 2%). Two respondents reported providing care to “other” (2%), and four did not report to whom they provided informal care. The majority of participants reported devoting fewer than 20 hours per week to informal caregiving ( $n=100$ , 87%). A smaller percentage of respondents indicated

spending more than 20 hours per week caregiving ( $n=15$ , 13%). Five participants (4.2%) did not report the number of hours devoted to informal caregiving. Caregivers reported providing care in their own home ( $n=49$ , 41%), the care recipient's home ( $n=44$ , 37%), or another setting ( $n=19$ , 16%) such as living facilities, residential treatment facilities, or some other kind of health care facility. Eight participants did not report where they provide caregiving.

### **Burden of Caregiving**

In the current study, burden of caregiving was defined as the number of hours devoted to caregiving and the length of time engaged in a caregiver role. Burden of caregiving also includes the self-reported strain experienced by the caregiver as a result of providing assistance with Activities of Daily Living (ADLs), performing personal care tasks (e.g. dressing, bathing, toileting, eating, grooming) and fulfilling Instrumental Activities of Daily Living (IADLs), such as providing transportation and housekeeping, obtaining and preparing meals, and managing healthcare, insurance, and other services (NAFC & AARP, 2009). Burden of caregiving among participants was assessed using a modified version of the Caregiver Strain Index (CSI) consisting of 12 items that gauge long-term strain related to providing care to adults over the age of 18 (Thornton & Travis, 2003). The CSI provides participants with three response choices for each item: *yes*, *sometimes*, and *no*. Responses were scored as 3 points for each “yes” response, 2 points for “sometimes” response, and 1 point for “no.” Total CSI scores ranged from 12 to 36, with higher scores indicating a greater degree of strain. As seen in Table 1, the mean score for CSI was 25.51 ( $SD=5.06$ ) indicating that the average participant was experiencing moderate amounts of caregiving strain. Three fourths of all participants indicated experiencing low to moderate amounts of strain ( $n=80$ , 75.5%) and one fourth reported severe strain ( $n=26$ , 24.5%). Fourteen participants did not complete the CSI. A Cronbach's alpha was computed to assess the

internal consistency of the CSI. This measure showed good internal consistency and was deemed reliable for the sample (Cronbach's  $\alpha = .898$ ).

Table 1  
Total Scale Scores

Name of Scale	<i>M</i>	<i>SD</i>	Range
Caregiving Strain Index* (CSI)	25.51	5.06	12-36
CES-D*	36.6	5.52	29-58
HRQOL-R*	5.98	3.09	3-20
Self-Care Assessment	63.80	6.79	47-77
Satisfaction with Life	26.10	5.85	10-35
MSPSS	74.07	10.44	3-80

\*SurveyMonkey® ([www.surveymonkey.com](http://www.surveymonkey.com)) was utilized to administer the survey. SurveyMonkey® does not code items as zero. The minimum score of 3 of the 6 published scales used in the current study was 0; thus, the minimum score was recorded as 1.

### Depressive Symptomology

The current study operationalized depressive symptomology according to diagnostic criteria that comprise a MDE, as defined by the DSM-IV-TR, as feelings of melancholy and having a downcast mood, failure to enjoy formerly interesting activities, loss of appetite, insomnia, psychomotor agitation or slowing of typical physical movement, continual feelings of exhaustion despite rest, feelings of guilt, inability to make a decision, difficulty concentrating and thoughts of suicide (APA, 2000). Depressive symptomology was assessed with the 20-item CES-D scale, developed for use with non-clinical populations, to assess the duration and intensity of depressed mood in relation to other variables (Radloff, 1977). Participants in the present study were asked to rank their level of agreement with each item using a 4-point Likert scale: *rarely or none of the time, some or a little of the time, occasionally or moderate amount of*

*time, most or all of the time* (Radloff, 1977). Higher scores indicated greater depressive symptomology, defined as occurring more frequently during the previous seven days (Radloff, 1977). Four positively worded items were reverse coded prior to analysis. As seen in Table 1, total CES-D scores ranged from 29 to 58, and the mean score was 36.6 ( $SD=5.52$ ). Three fifths of respondents ( $n=65$ , 59.6%) reported low levels of depression. Cronbach's alpha was computed to assess the internal consistency of the CES-D. The obtained alpha was .712, indicating adequate reliability of the CES-D for this sample.

### **Physical Health**

In the current study physical health was operationalized as the body operating normally or as intended. Caregivers' perception of their physical health was measured using the Healthy Days Core Module (CDC HRQOL-4), a 4-item questionnaire that allowed respondents to rate their perceived level of general physical health (CDC, 2000). The scale provides an estimate of the number of days, during the previous month, that the participant felt his/her general physical or mental health declined. The first question of this scale requested participants to rate their health using to a 5-point Likert scale, with response options including *excellent*, *very good*, *good*, *fair*, and *poor*. As can be seen in Table 2, the majority of respondents reported their self-perceived general health as excellent, very good, or good ( $n=106$ , 89%). Approximately one in ten reported their health as fair or poor (10.9%). Three additional open-ended items asked participants to record the approximate number of days that they experienced declines in physical and mental health, which may have kept them from engaging in usual activities during the previous 30 days. The total CDC HRQOL-4 scale score was calculated by summing the total number of unhealthy days. As seen in Table 1 scores ranged from 3 to 20, and the mean overall score was 5.98 ( $SD=3.09$ ). The largest proportion of participants was in good health, with 80.3%

reporting fewer than 7 days when their health was in decline during the previous 30 days.

Cronbach's alpha was computed to assess the internal consistency of the CDC HRQOL-4. The obtained alpha was .756, indicating adequate reliability for the current sample.

Table 2  
Frequencies of HRQOL-4: General Health

<b>Scale Score</b>	<b>Frequency</b>	<b>Percent</b>
<b>Excellent</b>	19	15.8
<b>Very Good</b>	49	40.8
<b>Good</b>	38	31.7
<b>Fair</b>	11	9.2
<b>Poor</b>	1	.8
<b>Don't Know/Missing</b>	2	1.6
<b>Total</b>	120	100.0

### **Self-Care**

Self-care was defined in the current study as the activities in which social workers consciously engage to purposefully relieve the stress resulting from helping and listening to clients (Moore et al., 2011). Self-care activities may include mindfulness, meditation, exercise, and eating well, as well as steps taken to ensure physical and emotional well-being (Radey & Figley, 2007). The self-care scale in the current study was adapted from the 75-item Self-Care Assessment (Saakvitne, Pearlman, & Staff, 1996), which asks participants to rate their degree of involvement in self-care activities with a 5-point Likert scale. A managerial decision was made to eliminate redundancy and to reword all double- and triple-barreled questions included in original scale, as well as to reduce the number of response options. The revised Self-Care Assessment included 20 items to which participants responded with *never*, *rarely*, *occasionally*,

or *frequently*. Higher scores indicated greater levels of involvement in self-care activities. As seen in Table 1, scores ranged from 47 to 77 and the total mean score was 63.81 ( $SD=6.799$ ), indicating moderately high levels of involvement in self-care activities. Approximately three fourths ( $n=85$ , 74.5%) of all participants reported engaging in self-care activities at least occasionally. A Cronbach's alpha was computed to assess the internal consistency of the Self-Care Assessment, and the resulting alpha was .744, indicating adequate reliability of the measure for the sample.

### **Life Satisfaction**

Life satisfaction was defined in the current study as a sense of self-reported fulfillment and level of happiness gained from personal and professional roles (Perkins & Haley, 2010). Life satisfaction was measured with the Satisfaction with Life Scale, a 5-item self-report instrument developed to assess general life satisfaction (Diener, Emmons, Larsen, & Griffin, 1985). Participants were asked to rate their level of agreement with each item using a 7-point Likert scale (Diener et al., 1985). Higher scores indicated greater levels of satisfaction with many aspects of the respondents' lives. As seen in Table 1, respondents' scores ranged from 10 to 35, and the total mean score was 26.10 ( $SD = 5.85$ ), indicating moderately high levels of satisfaction. The majority of participants, nearly 86%, reported life satisfaction at average or higher levels. A Cronbach's alpha was computed to assess the internal consistency of the life satisfaction scale, and the resulting alpha was .841 indicating good reliability for the sample.

### **Social Support**

In the current study, social support was defined as social resources, including friends, family members, and significant others that together allow social workers to thrive (Radey & Figley, 2007). Social support was measured with the Multidimensional Scale of Perceived Social

Support (MSPPSS), a 12-item, self-report instrument for determining quantity and quality of perceived support as a mediating factor for stress (Zimet, Dahlem, Zimet, & Farley, 1988). Participants were asked to rate their degree of agreement with each of the 12 statements, using the following 7-point Likert scale: *1=Very Strongly Disagree, 2=Strongly Disagree, 3=Mildly Disagree, 4=Neutral, 5=Mildly Agree, 6=Strongly Agree, 7=Very Strongly Agree* (Zimet, Dahlem, Zimet, & Farley, 1988). As can be seen in Table 1, respondents' scores ranged from 30 to 80, with a total mean score of 74.08 ( $SD = 10.44$ ), indicating relatively high levels of social support. The majority of participants reported having intact support systems, with 97% ( $n=110$ ) indicating moderate to high levels of social support. A Cronbach's alpha was computed to assess the internal consistency of the social support scale, and the resulting alpha was .925 indicating excellent reliability for the sample.

As an additional measure of support, participants were asked to write the relationship of up to five people on whom they may rely for support. This latter researcher-developed item was based on the Purdue Social Support Scale, a self-report instrument for determining quantity and quality of perceived social support (Burge & Figley, 1987). This information regarding the source of social support was measured on the nominal level. The majority of respondents indicated a spouse or partner as their primary source of social support ( $n=69$ , 58%). Additional respondents listed friends ( $n=24$ , 20%), parent ( $n=9$ , 7.5%) or a sibling ( $n=7$ , 6%) as supportive individuals.

### **Relationship between Caregiving Strain and Depressive Symptomology**

The current study hypothesized that burden of caregiving was positively correlated with depressive symptomology. Table 3 shows a correlation matrix that was computed to examine interrelationships among these and other study variables of interest. As seen in Table 3,



caregiving strain showed only a very weak negative association with depressive symptomology ( $r = -.188$ ), indicating that depressive symptomology increased as burden of caregiving decreased. This association was not significant.

### **Interrelationships among Caregiving Strain, Physical Health, Self-Care, Life Satisfaction, and Social Support**

The current research hypothesized that caregiving strain was negatively correlated with physical health, self-care, and life satisfaction. As seen in Table 3, caregiving strain showed a significant, and moderately low negative correlation with physical health ( $r = -.255, p < .05$ ), indicating that as caregiving strain increased, physical health decreased. Caregiving strain showed only a very weak positive association with self-care ( $r = .061$ ) and life satisfaction ( $r = .181$ ), indicating that as caregiving strain increased, self-care and life satisfaction also increased. Social support showed a moderately strong and positive correlation with both self-care ( $r = .355$ ) and life satisfaction ( $r = .454$ ) indicating that as social support increased so did self-care and life satisfaction (see Table 3).

The current research also sought to understand the experiences among social workers with additive caregiving responsibilities. The variable, additive caregiving, was defined as those social workers engaged in direct practice who had responsibilities for children under the age of 17 in addition to informal unpaid caregiving responsibilities for adults over the age of 18. The researcher hypothesized that among those with additive caregiving responsibilities, social support would be positively correlated with both self-care and life satisfaction. The subsample consisting of those with additive caregiving responsibilities included only 32 participants. As the result of the small subsample size, and low statistical power (Rubin & Babbie, 2010) these additional analyses were not undertaken.

Table 3  
Interrelationships Among Caregiving Strain, Depression, Self-Care, Social Support, and Life Satisfaction

Variable	1	2	3	4	5	6
1 Caregiving Strain	-	-.255*	-.188	.061	-.066	.181
2 Physical Health	-	-	.430*	-.220*	-.006	-.313*
3 Depression	-	-	-	-.141	-.051	-.385*
4 Self-Care	-	-	-	-	.355*	.359*
5 Social Support	-	-	-	-	-	.454*
6 Life Satisfaction	-	-	-	-	-	-

\* $p < .05$

### Differences in Variables of Interest Between Men and Women

*T*-tests were computed to determine whether there were differences in the mean scale scores (burden of caregiving, physical health, depression, self-care, social support and life satisfaction) between male and female social workers. The mean score on the self-care scale was higher for female social workers ( $M=64.61$ ,  $SD=6.35$ ) than for male social workers ( $M=60.92$ ,  $SD=7.63$ ). This difference was significant at  $t(112)=2.456$ ,  $p < .05$ . No differences between male and female social workers emerged with respect to burden of caregiving, physical health, depression, social support or life satisfaction. Although no statistically significant differences emerged between men and women on the measure of social support, the mean score for men (70.72) was lower than that for women (75.022) and there was much greater variability for men ( $SD=12.05$ ) than for women ( $SD=9.81$ ).

## **CHAPTER 6: DISCUSSION**

The current cross-sectional study sought to describe the experiences of professional caregivers (i.e. social workers in direct practice) who also provided informal, unpaid care to an adult. It is well documented that caregiving may negatively affect caregivers physical and mental health (AARP Public Policy Institute, 2011). According to the AARP Public Policy Institute (2011) between 40% and 70% of all unpaid caregivers may experience depressive symptomology. As many as 35% of all caregivers rate their own physical health as being compromised by chronic ailments such as heart disease, immune deficiency, elevated blood pressure, stroke, insomnia, or substance use (AARP Public Policy Institute, 2011). However, there is a gap in the literature examining caregiver strain among social workers who also provide informal caregiving. Although social work researchers have examined compassion fatigue (Adams et al., 2006; 2008; Figley, 2002; Radey & Figley, 2007), the present study is the first known study to specifically examine the interrelationships among caregiving characteristics, burden of caregiving, depressive symptomology, physical health, self-care, life satisfaction, and social support among social workers engaged in direct practice.

This study hypothesized that caregiving strain would be positively correlated with depressive symptomology. The results showed only a very weak negative association between these two variables. This was an unexpected result given the findings of other studies (Giovanetti et al., 2009; LeBlanc et al., 2003; Pavalko & Woodbuy, 2000) that show a positive correlation between the burden of caregiving and depressive symptomology. The hypothesis that the burden of caregiving would be negatively correlated with physical health, self-care, and life satisfaction was partially confirmed. Results showed that as burden of caregiving increased, physical health declined among participants in this study. This is consistent with other studies including the

report by AARP Public Policy Institute (2011) and MetLife Study (Albert & Shulz, 2010). However, caregiving strain showed only a very weak positive association with self-care and life satisfaction, indicating that as caregiving strain increased, self-care and life satisfaction also increased. This latter result was consistent with the caregiving research of Perkins and Haley (2010), who unexpectedly found that incremental caregiving responsibilities were not associated with low life satisfaction. Quite the opposite, the caregivers in their (Perkins & Haley, 2010) study expressed feelings of expertise and satisfaction from their caregiving roles. Löckenhoff et al. (2011) asserted that the caregiver's personality, management of stress and life outlook influenced his/her caregiving experience, perceived strain and life satisfaction. The positive association between caregiving strain, self-care, and life satisfaction also may be explained by the social work research of Radey and Figley (2007) regarding compassion fatigue. These latter authors found that social workers who actively engage in self-care were able to tap new reserves of compassion for clients and maintain positive outlook.

The current study also examined interrelationships among social support, self-care, and life-satisfaction. The results confirmed the hypothesis that social support, self-care, and life-satisfaction were positively interrelated. This finding is consistent with research on social workers (Adams et al., 2006; 2008; Kim, 2011; Radey & Figley, 2007) whose compassion fatigue and burnout was moderated by a combination of social support, self-care and positive outlook. Finally, the current study examined differences among major outcomes of interest between male and female social workers ad hoc. Results showed significant gender differences in the practice of self-care, specifically female social workers engaged in self-care more regularly than male social workers. Although no statistically significant differences emerged

between men and women on the measure of social support, there was much greater variability for men than for women.

### **Discussion of Sample Characteristics**

Participants in the current study were primarily Caucasian (86%) females (78%) whose average age was 56 years old. The sample characteristics were most similar to other reviewed studies examining the experiences of social workers (e.g., Adams et al., 2006; 2008; Kim, 2011; Pooler, 2008; Siebert & Siebert, 2007; Strozier & Evans, 1998), in that participants were primarily Caucasian, middle-age women who were recruited through NASW. For example, in the study conducted by Adams et al. (2006), participants were Caucasian (89%) female (80%) licensed clinical social workers whose average age was 50 years old (80%). In the study by Siebert and Siebert (2007), the sample was similarly composed of Caucasian (80%) females (82%) between the ages of 36 and 55 years of age (62%). Unlike previous studies that used NASW membership to recruit participants, the present study identified potential participants through the state licensing board database. The similarity in demographic characteristics between participants in the current study and those in related research is likely due to the predominance of women (81%) engaged in social work (Center for Health Workforce Studies & NASW Center for Workforce Studies, 2006). According to NASW (2003) the majority of the American social work workforce is Caucasian (87%) and between the ages of 43 and 62 (68%).

The demographic characteristics of participants in the current study are similar to those of respondents reviewed in studies that examined caregiving. These latter studies also used samples primarily composed of Caucasian women, age 50 years and older, which is likely due to the predominance of women engaged in informal caregiving (NAFC & AARP, 2009). While respondents in the MetLife Mature Market Institute Juggling Act Study (NAFC & the National

Center on Women and Aging at Brandeis University, 1999) were predominantly females (76%) between the ages of 47 and 64 (77%) there was greater variability with regard to race and ethnicity than the current study. The racial and ethnic variability in the MetLife Juggling Act Study (NAFC & AARP, 1999) may reflect the population of NAFC and AARP members from which study participants were recruited. In addition the average age and health status of participants in the current study was different from that of participants in caregiving studies. For example, Giovanetti et al. (2009) used a sample of 308 caregivers age 65 and older who reported heavy utilization of health insurance. Similarly, Fredman et al. (2010) utilized a sample of 1069 women aged 69 and older recruited from a study examining bone density and hip fractures.

### **Social Workers and Caregiving Strain**

The study sample was composed primarily of social workers, who had earned a MSW as their terminal degree, with more than 23 years of experience. Over half of participants reported that they work full time (40 hours per week or more) in a social work capacity. The majority of participants indicated that they worked in direct practice, primarily as therapists or counselors. Others reported working as administrators, client educators, advocates, community practitioners, or in a university education setting. This was consistent with other social work studies (Adams, 2006; 2008; Kim et al., 2011; Strozier & Evans, 2010) that also focused on the experience of social workers engaged in direct practice.

In the current study participants comprising the final sample provided informal, unpaid care for an individual over the age of 18, in addition to their work responsibilities. More than half of the respondents reported caring for a parent, while others provided care for adult children, relatives, spouses, or friends. The majority of participants (87%) provided fewer than 20 hours per week to informal caregiving responsibilities. Three fourths of participants reported low to

moderate levels of strain. These results were unexpected in that participants were neither overwhelmed nor highly stressed by their multiple responsibilities (i.e. social work and informal caregiving). While more research is needed to determine whether the number of hours devoted to caregiving, or if employment played a part in buffering participants from caregiving strain, the results support contentions of Pearlin et al. (1990), and Skaff and Pearlin (1992) that the caregiving experience is highly individual. Caregiving strain exists on a continuum that is determined by multiple factors including condition of care recipient, the number of hours per week devoted to caregiving, the necessary interruptions and impact on typical routine, and the length of caregiving experience (Pearlin et al., 1990; Skaff and Pearlin, 1992). In addition, Pavalko and Woodbury (2000) found that those caregivers who maintained employment were buffered from against the strain of caregiving suggesting that time away from the caregiving role during the day potentially provided caregivers with needed respite and protection from what Skaff and Pearlin (1992) refer to as role engulfment. Thus, future research should include multivariate approaches that can identify and assess the relative importance of potentially relevant variables on caregiver strain.

### **Caregiving Strain and Depressive Symptomology**

Depressive symptomology was assessed with the CES-D scale (Radloff, 1977) and three fifths of respondents reported low levels of depression. The present study hypothesized that burden of caregiving would be positively correlated with depressive symptomology. As seen in Table 3 caregiving strain showed only a very weak negative association with depressive symptomology. This finding was unexpected given the corpus of social work research showing association among direct practice, compassion fatigue, and burnout, and depressive symptomology. For example, Strozier and Evans (2010), found a significant sub-sample of social

workers experienced depression and anxiety as the result of their work professionally caring for clients with chronic mental illness. Pooler (2008) also found high levels of depressive symptomology among social workers in direct practice. Several researchers have examined the work conditions and personal characteristics that might help social workers avoid compassion fatigue, burn out and depression. For example, Adams et al. (2006; 2008) found that supportive work conditions and a positive personal outlook could counter depressive symptomology among social workers. Figley (2002) contends that psychotherapists who engage in self-care may be buffered from some of the negative psychological impacts of caring for others. The participants in the current study reported relatively high levels of self-care and social support, suggesting that a multivariate approach would be useful for assessing these interrelationships.

Depressive symptomology is also a common variable in caregiving studies. Skaff and Pearlin (1992) and Pavalko and Woodbury (2000) found caregiving strain highly correlated with depression especially among long-term caregivers. Giovanetti et al. (2009) found caregiving strain negatively impacted participants' physical and psychological health and thus interfered with work productivity. However, Perkins and Haley (2010) found that incremental caregiving responsibilities (i.e. for more than one person) did not equate to greater depression. The caregivers in Perkins and Haley's (2010) study expressed feelings of pride, expertise, and strong life satisfaction. Similarly, Löckenhoff et al. (2011) notes that caregivers' perceived mental health is highly influenced by factors including personality and outlook. Additional research is needed to determine what variables, such as social support or self-care, may mediate depression among the study sample.



### **Caregiving Strain, Physical Health, Self-Care and Life Satisfaction**

In the current study physical health was assessed with the HRQOL-4 (CDC, 2000). The majority (89%) of participants responded that their general health was excellent, very good, or good. Self-care was assessed with a modified version of the Self-Care Assessment (Saakvitne et al., 1996). Three-fourths of participants reported that they engage in self-care activities at least occasionally. Participants also completed the Satisfaction with Life Scale (Diener et al., 1985). The majority of participants (86%) indicated life satisfaction at average or higher levels.

The study hypothesized that the burden of caregiving would be negatively correlated with physical health, self-care, and life satisfaction. Results showed that caregiving strain was negatively related to social workers' physical health. This association could be due to the stress experienced by caregivers (Albert & Shulz, 2010; Giovannetti et al., 2009) and to a possible neglect of personal health needs while caring for others (Fredman et al., 2010; Siebert & Siebert, 2007; Strozier & Evans, 1998), or both. Although the relationship between caregiving strain and physical health was significant, it should be noted that 90% of participants reported their health as good or better. The fact that most respondents in the current study reported good health echoes research conducted by Pavalko and Woodbury (2000). These latter authors contend it is difficult to determine the physical effects of caregiving in a study that only examines caregivers' health at a single point in time. Pavalko and Woodbury (2000) recommend a longitudinal approach for understanding caregivers' health over time, which may show periods of stability and decline due to caregiving strain.

In the current study caregiving strain showed a very weak positive association with self-care and life satisfaction, indicating that as caregiving strain increased, self-care, and life-satisfaction also increased. These results may be explained by the literature regarding to social

workers and compassion fatigue. Radey and Figley (2007) contend that self-care may positively influence a social worker's satisfaction with not only their profession, but also with life. In the caregiving literature, Löckenhoff et al. (2011) asserts the caregiving experience is dependent on the outlook and personality of the caregiver. Social workers' personality traits, including their identity as helpers, along with knowledge of the importance of self-care may allow them to better manage unpaid informal caregiver strain as compared to other professionals. It is possible that employees in other fields may not fare as well. For example, Albert and Shulz's (2009) research on behalf of MetLife focused on 17,097 employees working in the manufacturing sector. Those with caregiving responsibilities suffered from more chronic illnesses, and depressive symptomology as compared to employees without caregiving responsibilities. Thus research that compares caregiver strain across different professional fields is needed to advance knowledge about relevant work-related characteristics.

### **Self-Care, Social Support and Life Satisfaction**

Social support was measured with the MSPSS an instrument for determining quality and quantity of perceived support (Zimet et al., 1988). Participants reported having intact support systems, with 97% indicating moderate to high levels of social support. The current study hypothesized that social support would be positively correlated with both self-care and life satisfaction. Social support showed a moderately strong positive correlation with both self-care and life satisfaction. These variables are important for understanding how social workers manage professional and personal caregiving responsibilities. Social workers in this study appear to provide informal unpaid caregiving with fewer sacrifices to health and well-being. Research shows that engaging in a self-care routine combined with social support allows participants to better manage the daily stress of their profession and informal caregiving roles (Radey & Figley,

2007). Adams et al. (2006; 2008) also found that social support buffered social workers from the physical and psychological strains of the profession. However, it is also possible that only healthy participants answered the survey, thereby resulting in a sampling bias. Participants may also have over reported social support, self-care, and life satisfaction. Rubin and Babbie (2010) refer to the tendency of individuals to report according to what they think is favorable as social desirability bias. Strozier and Evans (1998) found that social workers tend to under-report depressive symptomology, substance use, and physical illness. Similarly, Pooler (2008) found social workers had difficulty acknowledging impairment, asking for help, or both. Further research, using face-to-face interviews and greater assurance of confidentiality, is recommended to enhance the validity of social work participants' self-report in this area.

### **Limitations of the Current Study**

The current study has a number of limitations that should be acknowledged. As a cross-sectional study, it fails to capture the diverse experiences of participants over time. Additional limitations include problems regarding self-report, self-selection, and measurement reliability. The self-report survey instrument was administered via the Internet. While administering the survey in this manner was efficient and cost-effective, participants may answer according to what they think is more socially desirable (Rubin & Babbie, 2010). In addition, those social workers who responded to the survey may be distinctly different than those who did not complete it. For example, the respondents may be overly representative of a healthy subpopulation of caregivers. Social workers, too impaired by caregiving burden may have chosen not to respond to the survey. Another measurement issue is the reliability of the specific scales. It should be noted that one item was inadvertently omitted from the CSI: Feeling completely overwhelmed. Thus, the reliability of this scale for assessing the construct, caregiver

strain, was possibly compromised. However, an item-by-item analysis was conducted when the Cronbach's alpha was computed. Results showed that alpha levels for the 12 items, when one item was excluded, varied by less than .011, suggesting that the CSI scale was reliable for this sample, despite the omission of this one item. Future replications of the study should include the entire scale.

Cronbach's alpha was also calculated for each of the scales that comprised the survey instrument. While all scales had at least acceptable reliability,  $\alpha \geq .70$ , three scales (CES-D, HRQOL-4, and Self Care Assessment) had alphas below 0.80. Only the social support scale (MSPSS) had an alpha  $\geq .90$ . While these levels of internal consistency were acceptable (Rubin & Babbie, 2010), other measures of depression, health and self-care might have been better suited to this population. Pooler (2008) believes that because social workers identify themselves as professional caregivers this may make it difficult for them to ask for support or help. Strozier and Evans (1998) also acknowledge that social workers may misrepresent problems with their physical and mental health and distress. As such, in-person or telephone based interviews that provide greater assurances of confidentiality regarding matters related to professional impairment may have yielded more truthful responses about respondents' health concerns.

The present study also suffered from sampling limitations as the result of using an availability sampling method, which compromises generalizability of the findings (Rubin & Babbie, 2010). Surveys were completed by 657 respondents, of which 82.5% were female ( $n=490$ ), and 85.7% were Caucasian ( $n=502$ ). Although respondents in the present research are consistent with those of social workers and characteristics of caregivers surveyed in previous research, the sample is not representative of social workers practicing in the United States, with

respect to gender and ethnicity; thus significant differences may be detected with a more diverse and representative sample.

Sample size ( $n=120$ ) and relatively low response rate (35%) are other issues that negatively affect the generalizability of the findings of the current study. Rubin and Babbie (2010) warn against using survey samples of fewer than 250 participants as this could potentially jeopardize representativeness. For example, an acceptable response rate of 50% (Rubin & Babbie, 2010) for the current study would have increased the number of respondents to 935 (as opposed to 657), thus enhancing the representativeness of the sample. Further, respondents self-selected whether or not they were willing and able to take the survey. Those social workers unwilling or unable to complete an on-line survey are not represented. It is also possible that those social workers over-burdened by caregiving responsibilities chose not to participate in the survey. Thus the current study may not be generalized to less healthy, satisfied and supported social workers. Different means of recruiting and administering the surveys may have yielded different results. Dura and Kiecolt-Glaser (1990) indicate that caregivers suffering from high levels of strain, depressive symptomology, and multiple demands on their time are less likely to participate in research. Perkins and Haley (2010) suggest that caregivers are more likely to participate in survey research if able to participate from home. Thus future research should employ face-face interviews in caregivers' homes to advance knowledge about those who likely are most burdened.

### **Merits of the Current Study**

The present study bridges multiple bodies of research including caregiving (Giovannetti et al., 2009; Pavalko & Woodbury, 2000; Pearlin et al., 1990; Perkins & Haley, 2010; Skaff & Pearlin, 1992) and social work (Adams et al., 2006; 2008; Figley, 2002; Pooler, 2008; Radey &

Figley, 2007). It is the first known study to specifically examine the interrelationships among caregiving, depression, physical health, self-care, life satisfaction, and social support among social workers engaged in direct practice. The study is theoretically grounded, incorporating the perspectives of various researchers. It utilized established and reliable scales that have been used with similar samples in previous research. Although the response rate was 35%, this response is consistent with that yielded by Internet-based survey research (Nulty, 2008).

Results showed caregiving strain was negatively correlated with physical health. This association could be due to the stress experienced by caregivers (Albert & Shulz, 2010; Giovannetti et al., 2009) and to a possible neglect of personal health needs while caring for others (Fredman et al., 2010; Siebert & Siebert, 2007; Strozier & Evans, 1998), or both. Social support showed a moderately strong and positive correlation with both self-care and life-satisfaction among social workers with informal caregiving responsibilities. This correlation is supported by the research of Radey and Figley (2007) who assert that social workers may renew their energy, outlook and ultimately capacity for caring with social support and through actively engaging in self-care. The present study paves the way for further research regarding the impact of informal caregiving on social workers, as well as identifies variables that may potentially mediate the impact of caregiving on this population.

### **Implications for Practice, Research, and Education**

In this section implications for the profession are discussed in terms of organizational practice and policies, future research, and education.

#### **Practice**

National data show 1 in 5 Americans are caregivers to adults, and roughly 75% of caregivers also work full or part time (AARP Public Policy Institute, 2011). Research in business

literature shows how personal caregiving can negatively affect productivity and performance, disrupt career paths, reduce management status and salary expectations, and drain financial resources (NAFC & the National Center on Women and Aging at Brandeis University, 1999). Social workers who assume informal caregiving responsibilities may or may not experience similar negative consequences both at home and in the workplace. Supervision, supportive colleagues, and continuing education are necessary not only for professional skills development, but also for social workers' sustained mental health and therefore effective practice (Hesse, 2002). Results of the current study suggest that although supervisors should be aware of the potential for depression and poor health, supervisors should adopt a strengths perspective that recognizes apparent resiliencies among subpopulations of social workers. Organizations should encourage healthy work practices through workshops and standards of best practice that include self-care, and social support to help social workers maintain their own health and continue to take care of clients. According to Radey and Figley (2007), self-care and social support are critical to social workers managing the stress of their professional and personal lives. The social workers in the current study appear to do just that. Pooler (2008) contends that social workers need to be educated about and encouraged to practice self-care on an ongoing basis. The results of the current study showed significant differences in the degree to which female and male social workers engaged in self-care. This suggests a possible gender difference in how self-care is perceived and implemented by social work supervisees. Supervisors should therefore be aware of the possibility that the male supervisees may need additional encouragement to practice self-care.

## **Research**

This is the first known study to examine the informal caregiving experiences of social workers. While organizations such as NAFC AND AARP have teamed with major corporations such as MetLife (2009) to finance critical research into the interrelationship of informal caregiving and employment, no such partnership exists investigating the impact of informal caregiving on social workers and other helping professionals. Future research that uses a more representative sample as well as incorporates a longitudinal design will more fully capture the experiences of social workers over time. Such research could also benefit from qualitative inquiry to explore social workers' additive caregiving responsibilities that were not addressed in the current study. Methodology that includes face-to-face interviews should be utilized to reduce the risk of a social desirability bias (Rubin & Babbie, 2010). The current study suggests complex interrelationships among variables. A multivariate approach may help determine the relative importance of amount of caregiving and employment, and other related variables on caregiving strain. A multivariate approach would also allow an examination of all additional relevant variables of interest, including social workers' knowledge and practice of self-care, use of professional support systems and training.

## **Education**

The current study also has implications for social work education. As informal caregiving becomes increasingly prevalent in the United States, social work educators should consider infusing specific content related this critical issue into core and elective course work. Results of the present study add weight to the importance of self-care and social support, for social workers who take on caregiving, in particular. Although the current study does not permit causal inference, the results suggest that continuing education opportunities to communicate the



importance of social support and self-care to social workers engaged in direct practice who have caregiving responsibilities.

### **Concluding Statements**

It is widely acknowledged that individuals who engage in long-term informal caregiving may experience negative physical and mental health outcomes as the result of chronic stress (AARP Public Policy Institute, 2011). As ever-increasing numbers of Americans take on the role of informal caregiver, their health and well being may be as compromised as that of their care recipients. The current study shows that self-care and social support are associated with social workers' physical and psychological health, and these findings have important implications for practice, research, and education.

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# APPENDIX

## LSU INSTITUTIONAL REVIEW BOARD APPROVAL FOR EXEMPTION FROM INSTITUTIONAL OVERSIGHT

### Application for Exemption from Institutional Oversight

Unless qualified as meeting the specific criteria for exemption from Institutional Review Board (IRB) oversight, ALL LSU research/ projects using living humans as subjects, or samples, or data obtained from humans, directly or indirectly, with or without their consent, must be approved or exempted in advance by the LSU IRB. This Form helps the PI determine if a project may be exempted, and is used to request an exemption.

-- Applicant, Please fill out the application in its entirety and include the completed application as well as parts A-F, listed below, when submitting to the IRB. Once the application is completed, please submit two copies of the completed application to the IRB Office or to a member of the Human Subjects Screening Committee. Members of this committee can be found at <http://research.lsu.edu/CompliancePoliciesProcedures/InstitutionalReviewBoard%28IRB%29/Item24737.html>

- A Complete Application Includes All of the Following:
- (A) Two copies of this completed form and two copies of parts B thru F.
  - (B) A brief project description (adequate to evaluate risks to subjects and to explain your responses to Parts 1&2)
  - (C) Copies of all instruments to be used.
  - \*If this proposal is part of a grant proposal, include a copy of the proposal and all recruitment material.
  - (D) The consent form that you will use in the study (see part 3 for more information.)
  - (E) Certificate of Completion of Human Subjects Protection Training for all personnel involved in the project, including students who are involved with testing or handling data, unless already on file with the IRB. Training link: (<http://php.nihrtraining.com/users/login.php>)
  - (F) IRB Security of Data Agreement: (<http://research.lsu.edu/files/Item26774.pdf>)

**LSU**  
Institutional Review Board  
Dr. Robert Mathews, Chair  
131 David Boyd Hall  
Baton Rouge, LA 70803  
P: 225.578.8692  
F: 225.578.5983  
[irb@lsu.edu](mailto:irb@lsu.edu)  
[lsu.edu/irb](http://lsu.edu/irb)

1) Principal Investigator:  Rank:   
Dept:  Ph:  E-mail:

2) Co Investigator(s): please include department, rank, phone, and e-mail for each  
\*If student, please identify and name supervising professor in this space  
Dr. Catherine M. Lemieux, Associate Professor of Social Work, 578-1018, [clmieux@lsu.edu](mailto:clmieux@lsu.edu)

3) Project Title:   
Study Exempted By:  
Dr. Robert C. Mathews, Chairman  
Institutional Review Board  
Louisiana State University  
203 B-1 David Boyd Hall  
225-578-8692 | [www.lsu.edu/irb](http://www.lsu.edu/irb)  
Exemption Expires: 10/28/2015

4) Proposal? (yes or no)  If Yes, LSU Proposal Number   
Also, if YES, either  
☐ This application completely matches the scope of work in the grant  
OR  
☐ More IRB Applications will be filed later

5) Subject pool (e.g. Psychology students)   
\*Circle any "vulnerable populations" to be used: (children <18; the mentally impaired, pregnant women, the aged, other). Projects with incarcerated persons cannot be exempted.

6) PI Signature  Date  (no per signatures)

\*\* I certify my responses are accurate and complete. If the project scope or design is later changes, I will resubmit for review. I will obtain written approval from the Authorized Representative of all non-LSU institutions in which the study is conducted. I also understand that it is my responsibility to maintain copies of all consent forms at LSU for three years after completion of the study. If I leave LSU before that time the consent forms should be preserved in the Departmental Office.

Screening Committee Action: Exempted ☒ Not Exempted ☐ Category/Paragraph 2A  
Signed Consent Waived? (Yes/No) ☐  
Reviewer  Signature  Date

**Social Workers and Caregiving Experiences**

**Consent Script**

This anonymous survey collects information from Licensed Clinical Social Workers working in Louisiana. We are interested in your involvement in informal caregiving, as well as your social support, self-care, physical and mental health, and life satisfaction. The survey should not take more than 15 minutes to complete.

Participation is completely voluntary. There are no risks or benefits to taking this survey, and at anytime you may choose to not complete it without any penalties. Results of this study will be used for a Master's thesis and may be published, but no identifying information will be used. The researcher, Katherine Riker Sternberg may be reached at [kslem4@lsu.edu](mailto:kslem4@lsu.edu) should you have any questions regarding this study. Questions can also be directed to Dr. Bob Mathews, Director of LSU's Institutional Review Board at 225-578-8692.

By completing the survey below, I am indicating my consent to participate in the research study on knowledge about caregiving characteristics, social support, self care, health and life satisfaction.

This survey consists of 27 questions. Please read the instructions before each section carefully.

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Exemption Expires: 10/28/2015

## VITA

Katherine Riker Sternberg received her Bachelor of Arts in English literature from Skidmore College, and her M.B.A. in marketing and consulting from the Australian Graduate School of Management. In Fall 2010, Katie matriculated Louisiana State University to pursue her MSW degree. Upon completion she plans to work in direct practice with individuals and groups. Katie has interned over the course of the last two years at Louisiana State University, with the Center of Academic Success and Mental Health Services, counseling undergraduate students facing personal, familial, developmental, academic and social issues.

Prior to returning to pursue her M.S.W., Katie spent 20 years working in marketing consulting and strategic planning. In 1998 she founded The Marketing Source, LLC working primarily with the nonprofit organizations, healthcare, and small business sectors. She has lectured extensively and has a keen understanding of group facilitation, strategic planning, program development and implementation, budgeting, art direction, print production and project management. Katie received her early marketing training in brand management, product development, strategic planning and implementation, merchandise management, retail store management, catalog and website development within the Estee Lauder Companies, located in New York City.